Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 16, 2026

Administrator
Cook Community Hospital C&NC
10 SOUTHEAST FIFTH STREET
COOK, MN 55723

RE: CCN: 245392
Cycle Start Date: May 29, 2026

Dear Administrator:

On May 29, 2026, a survey was completed at your facility by the Minnesota Department(s) 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 1, 2026

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 1, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 1, 2026.

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

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 1, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Cook Community Hospital C&NC will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 1, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us

Cell: 651-279-5375 Office: 218-302-6186

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 29, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

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

tamika.brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division

330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

An equal opportunity employer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245392	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/27/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cook Community Hospital C&NC	**10 SOUTHEAST FIFTH STREET , COOK, Minnesota, 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
K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/27/2026. At the time of this survey, Cook Community Hospital C & NC was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us	K0000		06/22/2026

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 reverse for further 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.

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

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K0000 Bldg. 01	Continued from page 1 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. Cook Hospital C & NC is a 1-story building with a partial basement. The original building was constructed in 1960 with additions in 1966, 2000, 2005, and 2017. The original 1960 building and the 1966, 2000, and 2005 additions are all Type II (111) construction. The 2017 addition was determined to be of Type II(000) construction. The original building and all of the additions including the 2017 which had plans approved prior to July 5, 2016 were considered existing building for inspection purposes and the facility was inspected as 1 building. The facility has 2 smoke compartments and is separated from the hospital by a 2 hour fire rated wall. The building is fully fire sprinkler protected.. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 28 beds and had a census of 24 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		06/22/2026
K0345 SS = F Bldg. 01	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying	K0345	K0345- Per Maintenance Director- the annual testing and inspection documentation has been completed on 10/16/25 (see attached). The last semiannual testing and inspection	06/22/2026

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K0345 SS = F Bldg. 01	Continued from page 2 with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the Fire Alarm System per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.3, 14.4, 14.5.1, 14.6 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/27/2026 at 12:30 PM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that fire alarm system annual or semi-annual inspection is occurring. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K0345	Continued from page 2 documentation was completed on 4/11/25. This year's testing and inspection was completed on 04/02/26 by Pye Barker Fire & Safety however the documentation requested from Pye Barker has not been received after multiple attempts by the Maintenance Director. They sent the Smoke head testing report to the Maintenance Director, indicating they were onsite on 4/2/26 (see attached) performing the Semi-Annual, but left out the cover page and the Fire Panel testing report. Ongoing Monitoring: Maintenance Director will ensure that the required documentation is received within 7-10 days following the inspection. If not received Maintenance Director will immediately reach out to Pye Barker Fire & Safety. The Maintenance Director has created a QAPI to document ongoing monitoring Semi Annual and Annual testing.	06/22/2026
K0901 SS = F Bldg. 01	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and document review, the facility did not implement a risk assessment procedure for building systems designed to meet Category 1 through 4 in accordance with NFPA 99, Chapter 4. This deficient finding could have a widespread impact on the patients within the facility. Findings include:	K0901	K0901- Per Maintenance Director the Facility Risk Assessment (see attached) was in place on 5/27/26 upon survey indicating compliance was reached.	06/22/2026

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K0901 SS = F Bldg. 01	Continued from page 3 On 05/27/2026 at 1:30PM, it was revealed that at the time of the survey, the facility was unable to provide documentation of the Facility Risk Assessment required under NFPA 99 Chapter 4. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K0901		06/22/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.3.8. These deficient	K0918	K0918- Per Maintenance Director records were in place for the Annual Fuel Testing-Generator Fuel test completed by Ziegler Cat on the following dates: 5/22/23; 5/1/24; 5/20/25; 5/20/26. Therefore this was in compliance on 5/27/26 at the time of the survey. See all documents attached. Minimum monthly load requirements testing for the generator are in compliance with this being performed by Maintenance weekly. Therefore, this was in compliance on5/27/26 at the time o the survey (See attached document)	06/22/2026

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K0918 SS = F Bldg. 01	Continued from page 4 findings could have a widespread impact on the residents within the facility. Findings include: On 05/27/2026 at 1:30 PM, it was revealed by a review of available documentation at the time of the survey that the facility could not provide annual fuel testing had been completed on the diesel generator. 2. On 05/27/2026 at 1:30 PM, it was revealed by a review of available documentation during the time of the survey that the minimum monthly load requirements were unable to be verified due to the facility not providing the proper calculations for their diesel generator.An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K0918		06/22/2026
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on records review, observation, and interview,	K0921	K0921- Per Maintenance Director all PCREE is inspected and maintained by Agility Medical and NW Respiratory Services provides all Respiratory equipment, inspects and maintains this equipment continuously. See Attached Documents from Agility and NW Respiratory. This was in compliance on the date of the survey 5/27/26.	06/22/2026

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K0921 SS = F Bldg. 01	Continued from page 5 the facility failed to maintain documentation of inspections on all Patient-Care Related Electrical Equipment (PCREE) per NFPA 99, Health Care Facilities Code 2012 Edition, section 10.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/27/2026 at 12:15 PM, it was revealed that the facility failed to provide documentation on the electric beds for all residents, and that PCREE such as nebulizers, oxygen concentrators, portable suction units, and other electrical medical equipment was present at the facility was inspected and maintained. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K0921		06/22/2026
K0324 SS = E Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * 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 STANDARD is NOT MET as evidenced by: Based on a review of available documentation and	K0324	K0324 Maintenance Director has had the semi annual and annual kitchen hood inspection completed on 10/31/24, 4/11/25 and 10/16/25 (see attached). Therefore this was in compliance on 5/27/26 upon survey.	06/22/2026

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K0324 SS = E Bldg. 01	Continued from page 6 staff interview, the facility failed to inspect their kitchen hood per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.1 and 9.2.3, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, sections 4.1.5 and 11.2.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 05/27/2026 at 11:55 AM, it was revealed by a review of available documentation that at the time of the survey, the facility provided a kitchen hood suppression system report dated 04/02/2026 but could not provide the semi-annual report for 2025 6 months prior to the report provided. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K0324		06/22/2026
K0355 SS = D Bldg. 01	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed to maintain a portable fire extinguisher in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 6.1.3.3.1. This deficient finding could have an isolated impact on the patients within the facility. Findings include: On 05/27/2026 at 11:34 AM, it was revealed by observation that in the lower-level storage area there is a fire extinguisher in a cabinet blocked by computer boxes and equipment and is not easily accessible. An interview with the Environmental Services	K0355	K0355- Immediately on 5/27/26 Maintenance Director removed the clutter from in front of the fire extinguisher in the Lower-level storage area. Re-education was provided by the Maintenance Director to the IT Director to ensure full understanding that no items may be stored in front of the fire extinguisher cabinet. Ongoing Monitoring: Maintenance Director has created a QAPI on 6/22/26 to monitor this fire extinguisher cabinet and ensure no clutter is blocking the access to the cabinet. Audits will be completed 1x per week x 3 months by the maintenance department.	06/22/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245392	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/27/2026**

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Cook Community Hospital C&NC	**10 SOUTHEAST FIFTH STREET , COOK, Minnesota, 55723**

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K0355 SS = D Bldg. 01	Continued from page 7 Director verified this deficient finding at the time of discovery.	K0355		06/22/2026

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E0000	Initial Comments On 5/26/26-5/29/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a 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 facility acknowledge receipt of the electronic documents.	E0000		
F0000	INITIAL COMMENTS On 5/26/26-5/29/29, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was IN compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53922501C (2988826), H53922502C (2796850) with no deficiencies cited. The following complaints were reviewed: H53922503C (2591891) with deficiencies cited at F689 at a G at past noncompliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		

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 reverse for further 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.

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

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F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure care planned fall interventions were implemented for 1 of 4 residents (R29) reviewed for falls. This resulted in actual harm for R29 who fell and sustained a laceration to the forehead, requiring sutures. The facility implemented corrective action prior to the start of survey, and this is issued in past noncompliance. Findings include: R29's admission Minimum Data Set (MDS) dated 6/10/25, indicated significant cognitive impairment. Diagnosis included dementia with behaviors. Fall history indicated falls 2 to 6 months prior to admission along with a fall with fracture. R29's care plan dated 6/3/25, identified a risk for falls related to a history of falls at home and since admission, impaired balance, impaired mobility, impaired cognition, and psychotropic medication usage. Care planned interventions dated 6/10/25, included not to leave alone in wheelchair in her room. Care planned interventions dated 6/23/25, included bed sensors, Velcro alarmed seat belt, and chair clip alarms on at all times. R29’s Care Plan Summary for South Neighborhood dated 8/13/25, indicated R29 needed bed, chair and Velcro belt alarms on always and not to be left alone in her room when in the wheelchair. R29's nurses notes identified the following: - 8/15/25 at 6:30 p.m., R29 was physically aggressive with nurse assistant (NA) this afternoon. R29 was grabbing and pushing NA against wall and scratching NA’s arm and chest. R29 received medications for behaviors and became calmer and	F0689	"Past Noncompliance - no plan of correction required"	06/17/2026

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F0689 SS = G	Continued from page 2 more cooperative. - 8/16/25 at 10:01 a.m., two family members on the unit requesting information related to R29's fall the night prior. - 8/18/25 at 2:05 p.m., there was a late entry for the date of 8/15/25, that R29 had returned from the emergency room (ER) after receiving 10 stitches to a laceration on the right forehead. The facilities fall investigation and root cause analysis identified the following: R29 had an unwitnessed fall in her bathroom on 8/15/25 at 7:05 p.m., and received a laceration to her forehead, a scratch on the bridge of the nose, and a skin tear to the left wrist. R29's alarms were not sounding at the time of the fall. R29 had behavior problems and had refused to let staff place her seatbelt back on. In conclusion R29 self-transferred from the wheelchair to the bathroom in her room and the alarms were not on at the time of the fall as care planned. Registered nurse (RN)-A interview note dated 8/15/25 indicated R29 was calling out for her husband. R29 was found in her room lying on the floor in her bathroom with a puddle of blood under R29's forehead. The laceration was deep enough to see R29's skull. The note did not state if staff were with R29 in her room prior to the fall. During an interview on 5/27/26 at 2:42 p.m., nurse assistant (NA)-A stated on 8/15/25, evening shift had just started and R29 was having increased behaviors. R29 kept trying to get out of the chair and was setting off the lap belt alarms. She would not let me put the lap belt on her and R29 scratched my arms while I was trying to get the lap belt on her. I was finally able to get the lap belt on her after several minutes but do not remember if the alarm was on when I reattached the alarm. During an interview on 5/27/26 at 2:52 p.m., NA-B stated She was assigned to the south hall, the hall R29 was on. On 8/15/25 at approx. 6:00 p.m., NA-B saw R29 wheel herself into her room. The lap belt was in place but did not know if the alarm was turned on. NA-B stated she attempted to go into	F0689		06/17/2026

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F0689 SS = G	Continued from page 3 R29's room so R29 would not be alone in her room but the registered nurse (RN) stopped her and had NA-B go into another resident room to assist the RN with cares. No other staff were around to go be with R29 in her room, so R29 was in her room alone in the wheelchair. When they had finished the cares on the other resident the screams from R29's room were heard and staff entered the room and found R29 on the floor in the bathroom with blood on the floor.NA-A stated the staff were aware R29 could not be left alone in her room due to her high risk of falls and self-transfers in the past. On 5/28/26 at 10:44 a.m., RN-A, the PM nurse working on 8/15/25, was called but did not answer and was unable to leave a voicemail due to mailbox being full. On 5/28/26 at 10:54 a.m. RN-B, the AM nurse working on 8/15/25, was called nut did not answer. There was no voicemail to leave a message to call back. During an interview on 5/28/26 at 1:22 p.m., RN-C stated the fall investigation found that the care plan was not followed because the alarms were not turned on while R29 was in the wheelchair and alone in her room. During an interview on 5/29/26 at 9:09 a.m., the director of nursing (DON) stated staff should make sure the care plan is always followed, and alarms were turned on when R29 was out of bed and in the wheelchair. Facility policy Care Plan-Comprehensive Nursing dated 1/15/26, indicated a comprehensive car plan would be developed for each resident that included measurable objectives, and a timetable to meet a resident's medical, nursing, emotional, mental and psychosocial needs. The care plan was kept in the electronic health record and needed to be always followed. The noncompliance that began on 8/15/25 was corrected prior to the start of survey when the facility implemented a corrective action plan on 8/16/25. Actions taken included education related to the importance of following the care plan and education related to the use of lap belt alarms. Shift checks were initiated to verify alarms were on properly along with frequent checks of the residents and alarms. The education and audits were verified through interview and document review. The facility was able to demonstrate monitoring of the corrective action and sustained compliance.	F0689		06/17/2026

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F0732 SS = C	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community	F0732		06/17/2026

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F0732 SS = C	Continued from page 5 standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the nurse staff posting was posted daily and was updated to reflect the current staffing. This had the potential to affect all 24 residents residing in the facility. Findings include: On 5/27/26 at 2:15 p.m., the nurse staff posting was dated 5/26/26. On 5/27/26 at 4:10 p.m., the nurse staff posting was dated 5/26/25. On 5/28/26 at 6:58 a.m., the nurse staff posting was dated 5/26/26. On 5/29/2026 at 8:13 a.m., the nurse staff posting was dated 5/28/26. During an interview on 5/28/26 at 9:08 a.m., nursing assistant (NA)-A verified the nurse staff posting was dated 5/26/26. NA-A stated it was important for families and visitors to see how many staff were working. During an interview on 5/28/26 at 2:24 p.m. staffing coordinator (SC)-B stated she changed the nurse staffing hours on Thursdays for the coming week. SC-B stated she did not update the changes on the posted sheets but would make the changes in the computer after they occurred when she returned on Mondays. A review of the next week's schedules (5/28/26, 5/29/26, 5/30/28, 6/1/26) all had the census as 24. The schedule dated 5/30/26, had zeros for all staff listed and a census of 24. During an interview on 5/29/26 at 8:35 a.m., the director of nursing (DON) verified the nurse staff posting should be posted daily so anyone could see how many residents were in the facility and how many staff were working. The DON stated it was important so families could have confidence there was enough staff to take care of their family members.	F0732		06/17/2026

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F0732 SS = C	Continued from page 6 The Staffing – Care Center policy dated 1/26/26, identified the intent was to ensure sufficient staffing was in place to meet the needs of residents. The policy identified staffing hours would be posted on the bulletin boards in each household and the bulletin board located in the hallway leading to the Care Center from the Business Office. The policy identified the location was for residents, families, visitors, and staff but did not address how frequently the information “Daily Staffing” would be posted.	F0732		06/17/2026

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/27/2026. At the time of this survey, Cook Community Hospital C & NC was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us	K0000		06/22/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K0000 Bldg. 01	Continued from page 1 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. Cook Hospital C & NC is a 1-story building with a partial basement. The original building was constructed in 1960 with additions in 1966, 2000, 2005, and 2017. The original 1960 building and the 1966, 2000, and 2005 additions are all Type II (111) construction. The 2017 addition was determined to be of Type II(000) construction. The original building and all of the additions including the 2017 which had plans approved prior to July 5, 2016 were considered existing building for inspection purposes and the facility was inspected as 1 building. The facility has 2 smoke compartments and is separated from the hospital by a 2 hour fire rated wall. The building is fully fire sprinkler protected.. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 28 beds and had a census of 24 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		06/22/2026
K0345 SS = F Bldg. 01	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying	K0345	K0345- Per Maintenance Director- the annual testing and inspection documentation has been completed on 10/16/25 (see attached). The last semiannual testing and inspection	06/22/2026

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K0345 SS = F Bldg. 01	Continued from page 2 with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the Fire Alarm System per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.3, 14.4, 14.5.1, 14.6 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/27/2026 at 12:30 PM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that fire alarm system annual or semi-annual inspection is occurring. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K0345	Continued from page 2 documentation was completed on 4/11/25. This year's testing and inspection was completed on 04/02/26 by Pye Barker Fire & Safety however the documentation requested from Pye Barker has not been received after multiple attempts by the Maintenance Director. They sent the Smoke head testing report to the Maintenance Director, indicating they were onsite on 4/2/26 (see attached) performing the Semi-Annual, but left out the cover page and the Fire Panel testing report. Ongoing Monitoring: Maintenance Director will ensure that the required documentation is received within 7-10 days following the inspection. If not received Maintenance Director will immediately reach out to Pye Barker Fire & Safety. The Maintenance Director has created a QAPI to document ongoing monitoring Semi Annual and Annual testing.	06/22/2026
K0901 SS = F Bldg. 01	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and document review, the facility did not implement a risk assessment procedure for building systems designed to meet Category 1 through 4 in accordance with NFPA 99, Chapter 4. This deficient finding could have a widespread impact on the patients within the facility. Findings include:	K0901	K0901- Per Maintenance Director the Facility Risk Assessment (see attached) was in place on 5/27/26 upon survey indicating compliance was reached.	06/22/2026

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K0901 SS = F Bldg. 01	Continued from page 3 On 05/27/2026 at 1:30PM, it was revealed that at the time of the survey, the facility was unable to provide documentation of the Facility Risk Assessment required under NFPA 99 Chapter 4. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K0901		06/22/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.3.8. These deficient	K0918	K0918- Per Maintenance Director records were in place for the Annual Fuel Testing-Generator Fuel test completed by Ziegler Cat on the following dates: 5/22/23; 5/1/24; 5/20/25; 5/20/26. Therefore this was in compliance on 5/27/26 at the time of the survey. See all documents attached. Minimum monthly load requirements testing for the generator are in compliance with this being performed by Maintenance weekly. Therefore, this was in compliance on5/27/26 at the time o the survey (See attached document)	06/22/2026

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K0918 SS = F Bldg. 01	Continued from page 4 findings could have a widespread impact on the residents within the facility. Findings include: On 05/27/2026 at 1:30 PM, it was revealed by a review of available documentation at the time of the survey that the facility could not provide annual fuel testing had been completed on the diesel generator. 2. On 05/27/2026 at 1:30 PM, it was revealed by a review of available documentation during the time of the survey that the minimum monthly load requirements were unable to be verified due to the facility not providing the proper calculations for their diesel generator.An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K0918		06/22/2026
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on records review, observation, and interview,	K0921	K0921- Per Maintenance Director all PCREE is inspected and maintained by Agility Medical and NW Respiratory Services provides all Respiratory equipment, inspects and maintains this equipment continuously. See Attached Documents from Agility and NW Respiratory. This was in compliance on the date of the survey 5/27/26.	06/22/2026

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K0921 SS = F Bldg. 01	Continued from page 5 the facility failed to maintain documentation of inspections on all Patient-Care Related Electrical Equipment (PCREE) per NFPA 99, Health Care Facilities Code 2012 Edition, section 10.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/27/2026 at 12:15 PM, it was revealed that the facility failed to provide documentation on the electric beds for all residents, and that PCREE such as nebulizers, oxygen concentrators, portable suction units, and other electrical medical equipment was present at the facility was inspected and maintained. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K0921		06/22/2026
K0324 SS = E Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * 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 STANDARD is NOT MET as evidenced by: Based on a review of available documentation and	K0324	K0324 Maintenance Director has had the semi annual and annual kitchen hood inspection completed on 10/31/24, 4/11/25 and 10/16/25 (see attached). Therefore this was in compliance on 5/27/26 upon survey.	06/22/2026

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K0324 SS = E Bldg. 01	Continued from page 6 staff interview, the facility failed to inspect their kitchen hood per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.1 and 9.2.3, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, sections 4.1.5 and 11.2.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 05/27/2026 at 11:55 AM, it was revealed by a review of available documentation that at the time of the survey, the facility provided a kitchen hood suppression system report dated 04/02/2026 but could not provide the semi-annual report for 2025 6 months prior to the report provided. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K0324		06/22/2026
K0355 SS = D Bldg. 01	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observation, review of available documentation and staff interview, the facility failed to maintain a portable fire extinguisher in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 6.1.3.3.1. This deficient finding could have an isolated impact on the patients within the facility. Findings include: On 05/27/2026 at 11:34 AM, it was revealed by observation that in the lower-level storage area there is a fire extinguisher in a cabinet blocked by computer boxes and equipment and is not easily accessible. An interview with the Environmental Services	K0355	K0355- Immediately on 5/27/26 Maintenance Director removed the clutter from in front of the fire extinguisher in the Lower-level storage area. Re-education was provided by the Maintenance Director to the IT Director to ensure full understanding that no items may be stored in front of the fire extinguisher cabinet. Ongoing Monitoring: Maintenance Director has created a QAPI on 6/22/26 to monitor this fire extinguisher cabinet and ensure no clutter is blocking the access to the cabinet. Audits will be completed 1x per week x 3 months by the maintenance department.	06/22/2026

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K0355 SS = D Bldg. 01	Continued from page 7 Director verified this deficient finding at the time of discovery.	K0355		06/22/2026