



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 23, 2026

Administrator
Cokato Manor
182 SUNSET AVENUE
COKATO, MN 55321

RE: CCN:245412

Cycle Start Date: June 10, 2026

Dear Administrator:

On June 10, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 426-0175

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by September 10, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 10, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 17, 2026

Administrator
COKATO MANOR
182 SUNSET AVENUE
COKATO, MN 55321

RE: CCN: 245412

Cycle Start Date: June 10, 2026

Dear Administrator:

On July 28, 2026, the Minnesota Departments of Health and Public Safety, 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.

A handwritten signature in black ink, appearing to read 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245412		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
NAME OF PROVIDER OR SUPPLIER COKATO MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 182 SUNSET AVENUE , COKATO, Minnesota, 55321			
(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
E0000	Initial Comments On 6/7/26 to 6/10/26, 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			07/03/2026
F0000	INITIAL COMMENTS On 6/7/26 to 6/10/26, a standard recertification survey (S5412040-0) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54122777C (MN112516). NO deficiencies were cited. 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			07/03/2026
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-			F0657			Deficient Practice: Tag Number: F657 The facility failed to provide routine care conferences to allow for resident participation for 1 of 4 residents (R40). Corrective Action for Residents Affected

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245412		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
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F0657 SS = D	Continued from page 1 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide routine care conferences to allow for resident participation for 1 of 4 residents (R40) reviewed for care conferences. Findings include: R40's quarterly minimum data set (MDS) assessment dated 3/27/26, indicated R40 was admitted to the facility on 2/16/23, was cognitively intact and had the following diagnoses: high blood pressure, arthritis, and schizophrenia. R40's electronic medical record (EMR) revealed documentation of care conferences being held on 5/2/25, 10/7/25, 12/30/25, and 3/28/26. The EMR lacked evidence of a care conference being held between 5/2/25 and 10/7/25. During an interview on 6/8/26 at 9:10 a.m., R40 stated she understood what care conferences were but had not been invited to any type of care meeting over the past year.			F0657	Continued from page 1 R40 identified during the survey will have a comprehensive care conference scheduled which was completed on 6/24/26. Identification of Other Residents Potentially Affected The Director of Nursing (DON) or designee will conduct an audit for the last 90 days and determine if care conferences occurred without resident input. Any resident identified as not having documentation of resident/representative participation were corrected in the resident medical record or by contacting the resident/representative and revising the care plan as needed. Systemic Changes Implemented The facility will revise and reinforce its Care Conference Policy to ensure compliance with the requirements regarding resident participation in care planning. Education was provided to the Administrator, DON, Social Services, and interdisciplinary team members the importance of resident participation for care planning. A care conference observation form was implemented to document resident participation and the interdisciplinary team members. Monitoring for Continued Compliance The DON or designee will audit all scheduled care conference weekly, then monthly until compliance is met. Audit findings will be reported to the Quality Assurance and Performance Improvement (QAPI). Date of Compliance: All corrective actions will be completed by: July 3, 2026		07/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245412		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
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F0657 SS = D	Continued from page 2 During interview on 6/10/26 at 2:38 p.m., Licensed Social Worker (LSW) stated care conferences should be held at time of admission, then every three months and/or if there was a significant change of condition. LSW collaborated with other team members to gather pertinent care plan information. It was reviewed with the resident and their representative at the care conference. LSW stated she was responsible for scheduling and documenting care conferences in the EMR (electronic medical record). LSW could not provide documentation of a care conference being held between 5/2/25 and 10/7/25 and stated, "If it isn't documented it didn't happen". LSW stated it was important to have quarterly care conferences with the residents because they were the foundation of the care and residents had the right to be included in decisions that directly affect their care. During interview on 6/10/26 at 2:53 p.m., Administrator (Admin) stated care conferences were offered and held with the MDS quarterly schedule and as needed for a significant change of condition. Admin stated LSW was responsible for scheduling and documentation of care conferences for all residents. Admin stated when a care conference was held there should be a follow-up note in the EMR documenting the outcome of the meeting. Admin confirmed there was no documentation for a care conference being held for R40 between 5/2/25 and 10/7/25. Admin stated she expected care conferences to be held quarterly and should include the residents if they were able or their representative. Admin stated it was important to have quarterly care conferences so the residents can be involved in the planning of their care. A facility policy titled Cokato Manor Interdisciplinary Care Planning with a last review date of 2/2026 indicated the following: The residents and their designated responsible party are invited to attend the initial care planning conference and sequential conferences: annual and significant change conferences. Social worker to be responsible for leading the care conference meeting with the interdisciplinary team, resident and responsible party. Residents and families are invited to care planning meetings by the social worker. The social worker informs families of time constraints and monitors time during the care planning session.			F0657			07/03/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)			F0761	Deficient Practice: Tag Number: F761 The facility failed to ensure medications were appropriately labelled with an opened-on date to		07/07/2026

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F0761 SS = D	Continued from page 3 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were appropriately labeled with an opened-on date to prevent expired medications from being administered in 2 of 2 medications carts and 1 of 1 medication rooms reviewed for medication labeling and storage. Findings include: During observation and interview on 6/10/26 at 9:06 a.m., with registered nurse (RN)-A the North medication cart was reviewed and revealed the following: Nizoral shampoo- dated 9/10/24 (exp date:1/2026) Victosa insulin pen: no opened-on date Diclofenec Sod Top Gel: no opened-on date Biofreeze gel 4%: no opened-on date Hydrocortison cream 1%: no opened-on date			F0761	Continued from page 3 prevent expired medications from being administered. Corrective Action for Residents Affected All medication rooms, medication carts, refrigerators, treatment carts, and medication storage areas were immediately inspected. Any medications found without appropriate labeling, expiration dates, open dates were corrected or removed from service immediately. Identification of Other Residents Potentially Affected A 100% audit of all medication storage areas, medication carts, treatment carts, medication refrigerators, and medication rooms was completed by the Director of Nursing or designee. The Consultant Pharmacist reviewed medication storage practices with nursing leadership and provided additional guidance regarding F761 compliance. A complete audit of medication carts and medication room was completed on 6/12/2026. A QAPI meeting held 6/17/2026 with medical provider to review deficient practice and corrective actions. Systemic Changes Implemented The facility's Medication Labeling and Storage Policy were reviewed and updated to ensure compliance with CMS regulations and accepted pharmaceutical practices. Licensed nurses, medication aides, and other authorized staff received education on: Medication labeling requirements. Medication storage audits were incorporated into the Quality Assurance and Performance Improvement (QAPI) program. Monitoring for Continued Compliance The Director of Nursing or designee will complete audits 2 times per week of medication carts, medication rooms, treatment carts, and refrigerators for four weeks or until compliance is met. Then on-going audits will then continue weekly. Audit results will be reviewed at the facility's QAPI Committee meeting. Date of Compliance: July 7th, 2026		07/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245412		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
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F0761 SS = D	Continued from page 4 Biofreeze 4% gel: no opened-on date Nystatin cream100000 u: no opened-on date Diclofenec gel: no opened-on date Hemorrhoidal ointment: no opened-on date Calmoseptine ointment: dispensed 10/11/24; No opened-on date Diclofenca Sod Top Gel 1%: no opened-on date Diclofenca Sod Top Gel 1%: no opened-on date Triamcinolone Acetonide Cream (2 15-gram tubes): no opened-on date RN-A stated all eyedrops, creams, gels or anything that comes in a tube should be dated as soon as it is opened. RN-A stated all nurses and trained medication aides (TMA's) should be checking for an opened-on date when using these medications. During observation and interview on 6/10/26 at 9:31 a.m., the medication room was reviewed with RN-A and revealed the following opened medications: Sustane eye drops (2 bottles): no opened-on date Ketoconazole cream 2%: no opened-on dates Bacitracin ointment: no opened-on date Hydrocortisone cream 2.5%: sticker indicated dispensed on 4/23/24 -to be discarded 4/23/25- no opened-on date Dorzolamide Hydrochloride and Timolol Maleate Ophthalmic Solution 2% (2 bottles): no opened-on date During observation and interview on 6/10/26 at 10:03 a.m., with RN-B the East wing medication cart was reviewed and revealed the following: Hydrocortisone Cream 1%- no opened-on date Diclofenac Sodium Gel 1%: no opened-on date RN-B stated if a medication was missing the opened-on date it shouldn't be used because it could be expired, and the resident wouldn't get the actual prescribed dose.			F0761			07/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245412		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2026	
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F0761 SS = D	Continued from page 5 During interview on 6/10/26 at 3:01 p.m., Director of Nursing (DON) stated all medications should have an opened-on date clearly affixed so staff can identify when a medication was opened. DON stated she expected staff to affix an opened-on sticker and fill it out each time they opened a new bottle of eyedrops, creams, gels etc. DON went on to state staff should be checking this date every time they administer these medications. DON stated it was important to have the opened-on date because without it staff could inadvertently administer expired medications which would be less effective or ineffective. Facility policy titled Medication Storage in The Facility with a last review date of 2/26 indicated the following: When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated; The nurse shall place a "date opened" sticker on the medication and enter the date opened and the new date of expiration. The expiration date of the vial or container will be 30 days unless the manufacturer recommends another date or regulations/guidelines require different dating.			F0761			07/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245412		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 06/08/2026	
NAME OF PROVIDER OR SUPPLIER Cokato Manor				STREET ADDRESS, CITY, STATE, ZIP CODE 182 SUNSET AVENUE , COKATO, Minnesota, 55321			
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K0000 Bldg. 01	INITIAL COMMENTS An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/08/2026. At the time of this survey, Cokato Manor 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 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE			K0000			07/03/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245412		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 06/08/2026	
NAME OF PROVIDER OR SUPPLIER Cokato Manor				STREET ADDRESS, CITY, STATE, ZIP CODE 182 SUNSET AVENUE , COKATO, Minnesota, 55321			
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K0000 Bldg. 01	Continued from page 1 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. Cokato Manor was constructed at five different times. A one-story building with a partial basement was constructed in 1964 and determined to be Type II (000). Additions were added in 1984, 1994, 1999, and 2006. The 1999 addition included a Physical Therapy Area. The Assisted Living facility is separated from the Physical Therapy Area portion of the addition by a 2-hour fire-rated building separation wall. Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors that is monitored for automatic fire department notification. Smoke detectors located in the resident room report to a Nurse Call system that is monitored at the Nurses Station. The facility has a capacity of 56 beds and had a census of 54 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:			K0000			07/03/2026
K0345 SS = F Bldg. 01	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance			K0345	K0345 The identified fire alarm system deficiency was corrected on July 3rd, 2026. Documentation of corrective action has been placed in the Life Safety compliance binder.		07/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245412		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 06/08/2026	
NAME OF PROVIDER OR SUPPLIER Cokato Manor				STREET ADDRESS, CITY, STATE, ZIP CODE 182 SUNSET AVENUE , COKATO, Minnesota, 55321			
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K0345 SS = F Bldg. 01	Continued from page 2 A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This 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 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 06/08/2026 at 11:30 AM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that fire alarm system annual inspection is occurred. 2. On 06/08/2026 at 11:30 AM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that fire alarm system semi-annual inspection is occurring. An interview with the Maintenance Director and Administrator verified these deficient findings at the time of discovery.			K0345	Continued from page 2 Identification of other areas potentially affected: Any additional issues identified during review were corrected immediately. Systemic changes to prevent recurrence: The Administrator and Maintenance Director have implemented a preventive maintenance tracking system to ensure that all required inspections and testing are completed in accordance with NFPA 72 requirements. Contracts with licensed fire alarm vendor have been reviewed to ensure scheduled inspections and testing occur as required. Fire alarm records will be maintained in a centralized location and readily available for survey review. Monitoring: The Maintenance Director or designee will audit fire alarm testing and maintenance documentation monthly for three months, then quarterly thereafter. The results of the audits will be reported to the facility's safety committee, and corrective actions will be initiated if any deficiencies are identified. Completion Date: July 3rd, 2026.		07/03/2026
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____			K0353	K0353 The identified deficiency in the sprinkler system's five-year internal pipe inspection will be corrected on July 15th, 2026, by Brothers Fire and Security. Identification of other areas potentially affected: Any additional issues identified during review were corrected immediately. Systemic changes to prevent recurrence: The Administrator and Maintenance Director have implemented a preventive maintenance tracking system to ensure that all required inspections and testing are completed in accordance with NFPA 25 requirements.		07/15/2026

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K0353 SS = F Bldg. 01	Continued from page 3 c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1.2, and 5.3.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/08/2026 between 12:01 PM, it was revealed by observation that the five-year internal pipe inspection was not completed for the sprinkler risers. The last five-year inspection was completed on 05/12/2021 and the facility could not provide documentation showing that it had been completed at the time of the survey. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.			K0353	Continued from page 3 Contracts with licensed sprinkler system vendor have been reviewed to ensure scheduled inspections and testing occur as required. Sprinkler system records will be maintained in a centralized location and readily available for survey review. Monitoring: The Maintenance Director or designee will audit sprinkler system testing documentation quarterly. The results of the audits will be reported to the facility's safety committee, and corrective actions will be initiated if any deficiencies are identified. Completion Date: July 15th, 2026		07/15/2026
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			K0921	K0921 All patient care-related electrical equipment (PCREE) identified during the survey has been inventoried and inspected in accordance with NFPA 99 requirements. Identification of other areas potentially affected: An audit of patient-care-related electrical equipment throughout the facility was completed. Systemic changes: The facility has implemented a comprehensive inventory of all patient care-related electrical equipment		07/03/2026

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K0921 SS = F Bldg. 01	Continued from page 4 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, 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 06/08/2026 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 Maintenance Director and Administrator verified this deficient finding at the time of discovery.			K0921	Continued from page 4 A preventative maintenance schedule has been established to ensure testing is completed before equipment is placed into service, after repair, and at required intervals. Monitoring: The Maintenance Director or designee will perform monthly audits of patient care-related equipment records for three months, then quarterly thereafter. The results of the audits will be reported to the facility's safety committee, and corrective actions will be initiated if any deficiencies are identified. Completion date: July 3rd, 2026		07/03/2026