DEDA	DTMENT	OF	TIPAT TIL		TITINAN	SERVICES
DEFA		OF.	HEALIN	AND	HUMAN	SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	CARE/MEDICAID CERTIFICATION A		ID: 310F Facility ID: 00586
MEDICARE/MEDICAID PROVIDER NO. (L1) 245392 2.STATE VENDOR OR MEDICAID NO. (L2) 752547802 5. EFFECTIVE DATE CHANGE OF OWNERSHIP	 3. NAME AND ADDRESS OF FACILITY (L3) COOK COMMUNITY HOSPITAL C. (L4) 10 SOUTHEAST FIFTH STREET (L5) COOK, MN 7. PROVIDER/SUPPLIER CATEGORY 	&NC (L6) 55723 <u>02</u> (L7)	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint
(L9) 6. DATE OF SURVEY 05/29/2018 (L34) 8. ACCREDITATION STATUS:	01 Hospital 05 HHA 09 ESRD 02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 04 SNF 08 OPT/SP 12 RHC	13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 28 (L18) 13.Total Certified Beds 28 (L17) 14. LTC CERTIFIED BED BREAKDOWN	 10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With Program Requirements Compliance Based On: 1. Acceptable POC B. Not in Compliance with Program Requirements and/or Applied Waivers: 	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A 15. FACILITY MEETS	Following Requirements: 6. Scope of Services Limit 7. Medical Director 8. Patient Room Size 9. Beds/Room (L12)
18 SNF 18/19 SNF 19 SNF 28 (L37) (L38) (L39)	ICF IID (L42) (L43)	1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMARKS (IF APPLICAE			
17. SURVEYOR SIGNATURE	Date:	18. STATE SURVEY AGENCY AF	
Terri Ament, Unit Supervisor	06/08/2018 (L19)	Douglas S. Larson, Enfo	(L20)
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	E COMPLETED BY HCFA REGIONA 20. COMPLIANCE WITH CIVIL RIGHTS ACT:	21. 1. Statement of Financi	
		26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	(L30) <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change
(L27) B. Rescind S	(L44) uspension Date: (L45)		00-Active
28. TERMINATION DATE: (L28)	19. INTERMEDIARY/CARRIER NO.03001 (L31)	30. REMARKS	
31. RO RECEIPT OF CMS-1539 (L32)	2. DETERMINATION OF APPROVAL DATE 05/08/2018 (L33)	DETERMINATION APPRC	



Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245392

June 28, 2018

Ms. Teresa Debevec, Administrator Cook Community Hospital C&nc 10 Southeast Fifth Street Cook, MN 55723

Revised Letter

This letter will replace the letter dated June 8, 2018. We have corrected the effective date for certification.

Dear Ms. Debevec:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 25, 2018 the above facility is certified for:

28 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 28 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Dovers Stapson

Douglas Larson, Enforcement Specialist Minnesota Department of Health



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered June 8, 2018

Ms. Teresa Debevec, Administrator Cook Community Hospital C&nc 10 Southeast Fifth Street Cook, MN 55723

RE: Project Number S5392028

Dear Ms. Debevec:

On April 20, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 5, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 29, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 7, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 5, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 25, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 5, 2018, effective May 25, 2018 and therefore remedies outlined in our letter to you dated April 20, 2018, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Dourses Stapson

Douglas Larson, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4118 Fax: 651-215-9697 Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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CENTERS FOR MEDICARE & MEDICAID SERVICES

	CARE/MEDICAID CERTIFICATION I - TO BE COMPLETED BY THE STA		ID: 310F Facility ID: 00586
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245392 2.STATE VENDOR OR MEDICAID NO. (L2) 752547802 5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	3. NAME AND ADDRESS OF FACILITY (L3) COOK COMMUNITY HOSPITAL C. (L4) 10 SOUTHEAST FIFTH STREET (L5) COOK, MN 7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD		4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 04/05/2018 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	02 SNF/NF/Dual06 PRTF10 NF03 SNF/NF/Distinct07 X-Ray11 ICF/IID04 SNF08 OPT/SP12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 28 (L18) 20 (L17)	10.THE FACILITY IS CERTIFIED AS: A. In Compliance With Program Requirements Compliance Based On: 1. Acceptable POC	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code	6. Scope of Services Limit 7. Medical Director
13.Total Certified Beds 28 (L17)	X B. Not in Compliance with Program Requirements and/or Applied Waivers:	* Code: B *	(L12)
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 28	ICF IID	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38) (L39) 16. STATE SURVEY AGENCY REMARKS (IF APPLICAE	(L42) (L43)		
17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY A	PPROVAL Date:
Kimberly Settergren, HFE - NE II	05/02/2018 (L19)	Alison Helm, Enforce	ement Specialist 05/04/2018 (L20)
PART II - TO E	E COMPLETED BY HCFA REGIONA	L OFFICE OR SINGLE STA	ATE AGENCY
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	20. COMPLIANCE WITH CIVIL RIGHTS ACT:	 Statement of Finance Ownership/Control Both of the Above : 	Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE 23. LTC AGREE	MENT 24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION BEGINNIN 12/01/1986 (L24) (L41)		VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement	INVOLUNTARY 05-Fail to Meet Health/Safety
25. LTC EXTENSION DATE: 27. ALTERNAT A. Suspensi	TVE SANCTIONS on of Admissions: (L44)	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	<u>OTHER</u> 07-Provider Status Change 00-Active
(L27) B. Rescind S	uspension Date:		
28. TERMINATION DATE:	(L45) 29. INTERMEDIARY/CARRIER NO.	30. REMARKS	
	03001		
(L28)	(L31)		
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF APPROVAL DATE		
(L32)	(L33)	DETERMINATION APPRO	DVAL



Protecting, Maintaining and Improvingthe Health of All Minnesotans

Electronically delivered April 20, 2018

Ms. Teresa Debevec, Administrator Cook Community Hospital C&NC 10 Southeast Fifth Street Cook, MN 55723

RE: Project Number S5392028

Dear Ms. Debevec:

On April 5, 2018, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor Duluth Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Duluth Technology Village 11 East Superior Street, Suite 290 Duluth, Minnesota 55802-2007 Email: teresa.ament@state.mn.us Phone: (218) 302-6151 Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 15, 2018, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 15, 2018 the following remedy will be imposed:

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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

Cook Community Hospital C&NC April 20, 2018 Page 4

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 July 5, 2018 (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). This mandatory denial of payments will be based on the

Cook Community Hospital C&NC April 20, 2018 Page 5

failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 5, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

> Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 Cook Community Hospital C&NC April 20, 2018 Page 6

> St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Monty En

Michaelyn Bruer, Enforcement Specialist Minnesota Department of Health Health Regulation Division Program Assurance Unit phone 651-201-4117 fax 651-215-9697 email: <u>michaelyn.bruer@state.mn.us</u>

cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			· ·		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245392	B. WING _			04/	05/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	L C&NC) SOUTHEAST FIFTH STREET OOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00			
F 000	Emergency Prepare conducted on 4/2/1 recertification surve	iance with CMS Appendix Z edness Requirements, was 8, through 4/5/18, during a ey. The facility is in compliance Z Emergency Preparedness	F 00	00			
	standard survey wa the Minnesota Dep if your facility was in requirements of 42	nrough April 5, 2018, a as completed at your facility by artment of Health to determine n compliance with CFR Part 483, Subpart B, and ong Term Care Facilities.					
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 563 SS=F	on-site revisit of you validate that substa regulations has bee your verification. Right to Receive/De		F 56	63			5/15/18
	visitors of his or her her choosing, subje deny visitation when that does not impos resident.	esident has a right to receive r choosing at the time of his or ect to the resident's right to n applicable, and in a manner se on the rights of another					
	INTECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE 04/30/2018
	,						

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU			NO. 0938-0	
	OF CORRECTION	IDENTIFICATION NUMBER:	· ·			COMPLETED 04/05/2018	
		245392	B. WING				
IAME OF I	PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	AL C&NC) SOUTHEAST FIFTH STREET OOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5 COMPLE DAT	ÉTIO
F 563	Continued From pa	age 1	F 5	63			
		t provide immediate access to					
		ediate family and other relatives					
	of the resident, sub	ject to the resident's right to					
		onsent at any time;					
((((iii) The facility must provide immediate access to a resident by others who are visiting with the						
		dent, subject to reasonable restrictions and the resident's					
		hdraw consent at any time;					
	(iv) The facility mus						
	to a resident by any						
	provides health, so						
		ct to the resident's right to deny					
	or withdraw conser						
		t have written policies and ing the visitation rights of					
		g those setting forth any					
		or reasonable restriction or					
		restriction or limitation, when					
		ay apply consistent with the					
		s subpart, that the facility may					
		uch rights and the reasons for					
		y restriction or limitation.					
		NT is not met as evidenced					
	by: Based on interview	v and document review, the			The Cook Hospital and Care Center ha	as	
		w residents visitation rights			reviewed the policy and procedure	~~	
		outbreak. This had the			specific to resident rights to receive		
		Ill 26 residents residing in the			visitors of his or her choosing. The pol	licy	
	facility.	-			was found to be in compliance with		
					resident rights but was not followed.	r l	
	Findings include:				Upon family complaint the restriction of	ſ	
	The Influenza Like	Illness Line List from 2/25/18,			visitors was lifted. Staff education on policy and procedure for resident s rig	uhte	
		ntified 11 residents with			to visitors was conducted beginning	jiitə	
		ptoms. Three of the 11			04/07/18 including Long Term Care sta	ıff	
					and Infection Preventionist. This		
	residents had a col	nfirmed influenza A diagnosis.					
		nfirmed Influenza A diagnosis. case of Influenza A was on			education will be complete May 15, 20	18.	

Facility ID: 00586

If continuation sheet Page 2 of 43

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			E SURVEY PLETED
		245392	B. WING		04/	05/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0/2010
соок с	OMMUNITY HOSPITA	L C&NC	1	10 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 563	were placed on prea a resident on preca facility closed their through 3/12/18. On 4/2/18, at 6:27 p stated she had to s because of influenz facility would not all family members ha facility did not discu denying visitors, bu not going to allow v On 4/3/18, at 11:13 stated the facility ca not allowing any vis influenza outbreak was not sure how la the facility had calle could visit the facilit At 1:28 p.m. during R2, R9, R14, R25, administration shut including family dur added it was lonese On 4/4/18, at 10:09 stated the facility po when there was an been done in the pa residents were noti visitation; however and then the restrict	cautions, with the last day of butions being 3/8/18. The doors to visitors from 2/26/18, p.m. R25 was interviewed, and tay in her room for five days za. Further, R25 stated the low any visitors, and then id complained. R25 stated the uss with the residents about it told the residents they were risitors.	F 563	resident right to visitors it will be of facility annual education. Ed includes responsibility of facility immediate access to residents A.Any representative of the Sec the Department of Health and H Services B.Any representative of the Star C.The resident is individual phy D.The State long term care om E.The agency responsible for th protection and advocacy system developmentally disabled individ F.The agency responsible for th protection and advocacy system mentally ill G.The Resident Representative named family or acquaintances H. It is the facilities responsibili suggest visitors that are feeling restrict their visitation but provid and mask and / or gown to thos to visit a resident. To ensure our resident rights ar properly managed, the Cook Ca director of nursing or designee interview 2 residents per week to weeks. The DON or designee resident if they feel that any of to to have visitors have been denie facility. This audit interview will documented and updated at ID weekly and brought to QAPI con Director of Nursing is responsible overall compliance of this regular	ucation to allow by cretary of luman te /sician budsman ne n for duals ne n for the n for the n for the n for the n for the e gloves e wishing te gloves e wishing are Center will for 6 will ask the heir rights ed by our be T twice mmittee. le for the	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/02/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245392	B. WING			04/	05/2018
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	L C&NC			0 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 563 F 676 SS=D	At 10:33 a.m. the di stated he did not ev facility to visitors. H preventionist put the families complained On 4/5/18, at 1:32 p preventionist), state thought it would be visitation to the faci influenza outbreak. into account the res The facility policy V dated 1/10/17, iden right, and the care of access per their wis visitors. Activities Daily Livin CFR(s): 483.24(a)(§483.24(a) Based of assessment of a re resident's needs an provide the necessa ensure that a reside daily living do not di of the individual's ch that such diminution includes the facility §483.24(a)(1) A res treatment and servit or her ability to carr	irector of nursing (DON) ven question the closing of the e stated the facility infection e restrictions in place. After d, the restrictions were lifted. o.m. RN-C (the facility infection ed she did some research, and appropriate to restrict lity during the facility's RN-C stated she did not take sident's rights to have visitors. isitation in Long Term Care tified the resident had the center must provide immediate shes to family and non-family og (ADLs)/Mntn Abilities 1)(b)(1)-(5)(i)-(iii) on the comprehensive sident and consistent with the d choices, the facility must ary care and services to ent's abilities in activities of iminish unless circumstances inical condition demonstrate n was unavoidable. This ensuring that: ident is given the appropriate ces to maintain or improve his y out the activities of daily se specified in paragraph (b)		563			5/15/18

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		& MEDICAID SERVICES				. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION		E SURVEY IPLETED
		245392	B. WING		04/	05/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
COOK C	OMMUNITY HOSPITA	L C&NC		10 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 676	Continued From pa	ge 4	F 6	76		
		ovide care and services in ragraph (a) for the following ing:				
	§483.24(b)(1) Hygie grooming, and oral	ene -bathing, dressing, care,				
	§483.24(b)(2) Mobi including walking,	lity-transfer and ambulation,				
	§483.24(b)(3) Elimi	nation-toileting,				
	§483.24(b)(4) Dinin snacks,	g-eating, including meals and				
	(i) Speech,(ii) Language,(iii) Other functional	munication, including l communication systems. NT is not met as evidenced				
	Based on observat review, the facility facility facility facility	tion, interview, and document ailed to provide hearing aids in 1 of 2 residents (R15) unication.		Cook Hospital and Care reviewed the facility polic Care and Quality of Life. that these policies follow guidelines including resid	es on Quality of We have found regulatory	
	Findings include:			for a functional communi- and the use of it. We fee	cation system	
	3/6/18, identified R	imum Data Set (MDS) dated 15 was cognitively intact, had and wore hearing aids.		were not followed and the document the use of hea made challenging to our immediate audit of reside	e ability to ring aides was staff. An	
	hearing aid use.	ed 9/5/17, did not address		aides was conducted with communication device. R15 has been immediate	n the ly checked for	
	stated she gave he assistants at night t	o.m. R15 was interviewed and r hearing aids to the nursing to be stored on the medication I to state that this past week,		hearing aide usage and v compliance through staff audit. Staff will be educated beg	education and	

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		E & MEDICAID SERVICES	0.00			0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY IPLETED
		245392	B. WING		04/	05/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	ZIP CODE	
соок с	OMMUNITY HOSPITA	AL C&NC		10 SOUTHEAST FIFTH STREE COOK, MN 55723	T	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE)	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 676	Continued From pa		F 670		by May 15 to	
	stated she had req and was told by the them, and then new aids in at the time of voiced concerns th was having difficult On 4/3/18, at 4:07 stated R15 did not in when she started times NA-A had to NA-A stated the nut the medication carr give residents their On 4/4/18, at 7:56 wheelchair, went to the counter for breachearing aids in. On 4/4/18, At 8:33 handed R15's hear training. The nurse aids to R15, and as On 4/4/18, at 9:24 was responsible fo aids, because they for safety. Further, her she went witho days. R15's daugh concerns about R1 aids right away in t On 4/4/18, at 9:46 hearing aids were s	p.m. nursing assistant (NA)-A always have her hearing aids d her evening shift, and at request them from the nurse. Inses kept the hearing aids on t, and they were responsible to hearing aids in the morning. a.m. R15 left her room via the dining room, and sat at akfast. R15 did not have her a.m. registered nurse (RN)-B ring aids to the nurse in a in training brought the hearing ssisted her with placing them. a.m. NA-B stated the nurse r giving residents their hearing were on the medication cart NA-B stated R15 did report to ut her hearing aids for four ter had also brought up 5 not receiving her hearing		2018 and be complete ensure all staff have th Procedural change wa 04/30/18 as follows: *Evening shift nursing y hearing aide containers resident name to nurse *Nurse aide will take th place resident hearing after checking for dama *Nurse will bring contai medication locked cart *following morning or a the container will be br station and then given *IT department created our Meditech EMR sys to document the remove of the hearing aides. To other column for those hearing aide is not place unforeseen circumstan An audit of 3 residents weeks will take place b nursing or designee to of this procedure chang The director of nursing implementation of thes changes.	e process in place. Is implemented will bring individual s marked with a aide station. e container and aide in container age. ners to the for storage. s resident desires, ought to nurse aide to residents. I an intervention in tem for availability val and placement there is also an times when ced due to ces. per week for 6 y director of follow compliance ge. is responsible for	

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		AND HUMAN SERVICES				FORM	05/02/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245392	B. WING			04/(05/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
соок с	OMMUNITY HOSPITA	L C&NC			0 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 676	given when she adi RN-B stated they di residents received they were returned stated at times resid hearing aids at all, I or the hearing aids medication cart the to state many times don't receive their h felt the residents sh get up. On 4/4/18, at 10:09 problems with resid timely. RN-D stated documentation of w aids. RN-D reviewe hearing aid use was should be. On 4/4/18, at 2:28 stated there were o receiving her hearin receive them, the b On 4/5/18, at 10:40 to have hearing aid At 11:02 a.m. RN-E given in the mornin morning medication to see if R15 had he medication cart, an not on the cart. RN- nurses responsibilit their hearing aids, t	ministered their medication. id not document when their hearing aids, or when to the medication cart. RN-B dents don't receive their because the nurse may forget, were not returned to the right before. RN-B continued s residents, including R15, hearing aids until noon. RN-B hould receive them when they 0 a.m. RN-D stated there were dents getting their hearing aids d there should be when R15 received her hearing ed R15's medical record, s not on the care plan and p.m. family member (FM)-B ongoing issues with R15 ng aids, and when she did vatteries were frequently dead.	F	576			

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ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CONSTRUCTION	(X3) DA	<u>). 0938-039</u> TE SURVEY
ID PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	· · ·	G	COMPLETED	
		245392	B. WING		04	/05/2018
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	E	
COOK C	OMMUNITY HOSPITA	L C&NC		10 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 676	- 1	ige 7 aids were not missing.	F 67	6		
	-	aid use was requested and				
F 726 SS=D	not received. Competent Nursing CFR(s): 483.35(a)(F 72	6		5/15/18
	the appropriate corprovide nursing and resident safety and practicable physical well-being of each resident assessme and considering the diagnoses of the fal accordance with the at §483.70(e).	ave sufficient nursing staff with npetencies and skills sets to d related services to assure attain or maintain the highest l, mental, and psychosocial resident, as determined by nts and individual plans of care e number, acuity and cility's resident population in e facility assessment required				
	licensed nurses had and skill sets necess needs, as identified	facility must ensure that ve the specific competencies ssary to care for residents' I through resident described in the plan of care.				
	limited to assessing	iding care includes but is not g, evaluating, planning and ent care plans and responding				
	to demonstrate con techniques necess needs, as identified	nsure that nurse aides are able npetency in skills and ary to care for residents' I through resident described in the plan of care.				

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		& MEDICAID SERVICES	(X2) MUUT	TIPLE CONSTRUCTION	OMB NO.	E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED
		245392	B. WING		- 04/0	05/2018
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE	
соок с	OMMUNITY HOSPITA	L C&NC		10 SOUTHEAST FIFTH STR COOK, MN 55723	EET	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETIC DATE
F 726	Continued From pa	ige 8	F 7	26		
	review, the facility f were trained and as regarding crushing for 2 of 8 residents of eye drops using techniques to preve of 1 resident (R11) administration. Findings include: R11's History and F indicated R11's diag macular degenerat R11's signed physic included orders for support eye health) daily, Ultram (pain po three times daily anti-inflammatory) Artificial Tears eyec eyes four times daily anti-inflammatory) Artificial Tears eyec eyes four times daily to crush medicatio On 4/2/18, at 5:37 µ was observed durin crushed R11's nap (for Ocuvite), and the prior to administration administered the cr applesauce to R11. medications crushed an order for crushin	tion, interview, and document ailed to ensure nursing staff ssessed for competency medications without an order (R11, R19) and administration appropriate hand hygiene and ent cross contamination for 1 observed for eye drop Physical dated 7/10/17, gnoses included chronic pain, ion and esophageal strictures. cian orders dated 2/23/18, Ocuvite with Lutein (vitamin to o one tab by mouth (po) twice medication) 50 milligrams (mg) <i>y</i> , Aleve (nonsteroidal 220 mg po twice daily, and drops, instill 1 drop into both ly. R11's orders lack directions ns. o.m. registered nurse (RN)-A ng medication pass. RN-A roxen sodium (Aleve), I-vite ramadol (Ultram) medications ion of these medications. RN-A rushed medications in . RN-A stated R11 has ed, but did not know if R11 had ng medications. RN-A stated ere okay to crush as far as she		a medication administration together The policy did have provide addressing the compresentation together The policy did have provide administration technic in review of resident documentation and prote, no ill effects were R19 when medication together or in R19 when medication program 5/15/18 for nursing sraide group. Staff will competency during to 2018. It will consist a competency in physic psychosocial well-be be trained on proper administration of me be crushed, physicia crushing and administration of oph residents. Training fromplete by May 15 competency checklist.	und to be lacking in ponent of crushing of for our residents. proper medication que. vital signs, nurse physician progress ere found in R11 or ns were crushed ith improper hand administration. le goal of the facility are. The Cook Care nted a new n that will take effect taff and the nurse l be educated on this he 1st week of May of best-practice cal, mental and ing. Nursing staff will medication ing but not limited to dication that needs to n orders, individual stration of a and hygiene and othalmic drops for or nursing staff will be 2018. Annual st in a re-vamped mented for start date mpetency includes	

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	OMB NO. (X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	· ,	G		PLETED
		245392	B. WING		04/0	05/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
соок с	OMMUNITY HOSPITA	L C&NC		10 SOUTHEAST FIFTH STREET COOK, MN 55723	r	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 726	Continued From pa	ge 9	F 72	6		
	 On 4/2/18, at 5:59 p.m. RN-A verified R11 did not have an order to crush medications. On 4/3/18, at 11:43 p.m. RN-B was observed for medication pass. RN-B stated for the most part, R11 received his medications whole. RN-B stated R11 does better as the day goes on, but sometimes they crush his medications, depending on his swallowing ability. RN-B stated this morning they crushed R11's medications and gave them in three spoonfuls of applesauce. During this medication pass, R11 was observed to give R11 his tramadol whole in applesauce, 			further training, the met (demonstration, observa or verbal test) and staff verified competency and We have now had the o Medbridge join our tean education. We have pa Medbridge and will utiliz the following staff educa Wound Care Series: " Assessment and Docu Pressure Injuries " Assessment and Mana	ation, written test member who d date. opportunity to have n in staff artnered with te their expertise in ation:	
	oral medications ar cart. RN-B did not v administration. RN- medication first. RN open, touching the ungloved left hand, artificial tears into the tip of eye drop bottl repeated the practi- touching the tip of the eyelid. RN-B return	but difficulty. RN-B prepared and eye drops at the medication wash hands prior to medication B administered R11's oral J-B then held R11's right eye outside of his eyelid with her and administered a drop of the right eye while touching the e to R11's eyelid. RN-B fice on R11's left eye, again the eye drop bottle to R11's ed to the medication cart, on the cart, and opened the		Extremity Ulcers " Prevention of Pressure Nursing Assistants) " Prevention of Pressure Assessment and Care F " Topical Management of Injuries " Utilizing QAPI for Build Pressure Injury Program Fall Prevention Series: " Falls Series: Introduction Analysis " Falls Series: Applying	e Injuries: Risk Planning of Pressure ding an Effective n ion to Root Cause	
	cart drawer. When during eye drop add wore gloves, "Some eye drops in the me documented on the washing or sanitizin administration of ey resident's eyes, RN sanitizes her hands documenting on the	asked about wearing gloves ministration, RN-B stated she etimes." RN-B put away the edication cart, and computer. When asked about ing hands following <i>re</i> drops and touching a I-B stated she washes or after she is done computer. RN-B stated she ed her hands right away, after		Analysis to Falls "Falls Series: Causatio "Falls Series: Falls Solu Interventions Infection Prevention Sel "Sepsis: Early Recogni Rehospitalization "Creating an Antibiotic Program "The Role of the Infecti Long-Term Care Dementia Series: "How to Communicatio	n of Resident Falls utions & ries: tion to Avoid Stewardship on Preventionist in	

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		I AND HUMAN SERVICES <u>& MEDICAID SERVICES</u>				APPROVE 0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED		
		245392	B. WING _		04/	05/2018		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE			
соок с	OMMUNITY HOSPITA	AL C&NC		10 SOUTHEAST FIFTH STREET COOK, MN 55723				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE		
F 726	indicated R19's dia disease and osteop of related fractures R19's signed Physi included orders for mg po four times d order was NDDI (p lacked orders to cr On 4/3/18, at 11:54 acetaminophen, ar applesauce to R19 had an order to cru On 4/4/18, at 8:21 not received trainin RN-B stated they g medications or con stated she had rec eye drops, but she yesterday. RN-A's skills check RN-A had been tra administration, but medications. RN-B's orientation included training ar hand hygiene, and RN-B's checklist la crushing of medication (DON) was interview were not to be crus	Physical dated 6/28/17, agnoses included Alzheimer's penia (bone loss) with a history ician Orders dated 3/28/18, Tylenol (acetaminophen) 650 laily for arthritis. R19's diet ureed). R19's physician orders ush medications. It a.m. RN-B crushed R19's administered it in P. RN-B stated she thought R19 ush medications. a.m. RN-B stated they have ag on crushing medications. get orders for crushing incealing medications. RN-B eived training on administering just did not do it correctly klist dated 5/20/17, indicated ined in medication lacked training in crushing of checklist dated 2/9/16, and return demonstration on training on infection control. icked training regarding	F 72	 is Living with Dementia "Working with Dementia: Und Changes in Movement and Se "Depression, Delirium, Dementia: Sin a Complex Patient "Untangling Depression, Delinder Dementia: Screening and Ass Strategies "Key Indicators of Primary Definder "Overview of Psychosocial Is "Management of Aggressive The director of nursing or des observe 3 medication passes for 6 weeks and observation results and at facility QAPI. The director of nursing or des audit 3 medication passes wite EMR for proper documentation observation of the resident rig medication administration. The will be updated at IDT 2 times and at facility QAPI. The director of nursing or des observe 3 medication passes for 6 weeks for compliance of medications safely and effection regulations and procedure. To observation results will be updated the director of nursing is respinal 	ensation ntia: The 3 rium and essment ementias sues Behavior ignee will per week esults will times per ignee will hin Meditech n and hts of safe ne results per week crushing of vely per he lated at IDT y QAPI. ponsible for			

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	05/02/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245392	B. WING		04/	05/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	L C&NC		10 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 726 F 744 SS=D	licensed nurses on nurses should wash administration of ey without touching the The DON stated nu and sanitize or was administration of ey The facility policy Ad Long Term Care da to crush medication to physician orders, the pharmacist, and further directed med together unless cor- order, manufacture principles and stand The facility policy H directed hand hygie after each resident soap and water pric prior to passing out resident medication Treatment/Service f CFR(s): 483.40(b)(3) §483.40(b)(3) A res diagnosed with dem appropriate treatment maintain his or her mental, and psycho This REQUIREMEN by: Based on observat review, the facility factors	this yet. The DON verified in hands and glove prior to be drops, then instill eye drops a eye drop bottle to the eye lid. rses should remove gloves in hands immediately after re drops. dministration of Medication in ted 4/13/17, directed nursing is when necessary according manufacturer's information, d drug reference. The policy dications may be crushed itraindicated by physician r's information, or accepted dards. and Hygiene revised 1/18, ne to be done before and contact, and wash hands with or to setting up medication and medication, and in between administration. for Dementia 3) ident who displays or is nentia, receives the ent and services to attain or highest practicable physical, isocial well-being. NT is not met as evidenced ion, interview, and document ailed to ensure meaningful ided to 3 of 4 residents (R1,	F 726	5	nentia adult	5/15/18

Facility ID: 00586

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	r		0	<u>MB NO.</u>	0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			· · ·	E SURVEY PLETED
		245392	B. WING_			04/0	05/2018
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	L C&NC) SOUTHEAST FIFTH STREET OOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 744	Continued From pa	age 12	F 74	44			
	Findings include:	-			policy Behavioral Health LTC which reviewed 04/30/18 at IDT and sent Medical Staffing for approval the w	to reek of	
	indicated R1's diag dementia, agitation	hysical dated 1/31/18, noses included severe , mood instability, and chronic extensive to full assist with			May 7. Once approved staff educa will take place the same week with completion by May 15 2018. The p specific to care of behaviors includ	oolicy is	
	activities of daily liv				not limited to residents with demen cognitive disability. The goal of the Care Center is to give our resident	ntia and e Cook	
	2/5/18, indicated R others and was sor	1 sometimes understood netimes understood by others,			quality of life regardless of residen	t ability.	
	decision-making, h rejection of cares.	red cognitive skills for ad delusions and had no R1's MDS further indicated R1			Staff education and competency is in quality care of our dementia resi We have teamed up with Medbridg	dents. ge to	
		al and wandering behaviors 1 e assessment period.			assist us in our staff education and consist of: Dementia Series:	l will	
	somewhat importar	lated 11/9/17, indicated it was nt to R1 to listen to music, be things with groups of people,			" How to Communication When So is Living with Dementia " Working with Dementia: Understa		
	and go outside.				Changes in Movement and Sensat "Depression, Delirium, Dementia:	tion	
	11/15/17, for cognit R1 propelled own v	sessments (CAA) dated tive loss/dementia indicated wheelchair around the care erately impaired cognitive			D's in a Complex Patient " Untangling Depression, Delirium Dementia: Screening and Assessn Strategies		
	impairment, and wa decisions. R1's cog	as able to make simple daily gnitive loss CAA indicated R1 ing attention, and was easily			" Key Indicators of Primary Demen and How They Fit Together Psychosocial Issues Series:	tias	
	distracted. R1's CA indicated R1 did no	A for psychosocial well-being answer questions regarding cipation in favorite activities,			" Overview of Psychosocial Issues " Management of Aggressive Beha		
	CAA indicated R1 v	oods during activities. R1's would stay and observe kimately 45 minutes, or would			An immediate audit of our resident clarified we have 9 other residents potentially affected by lack of mean		
	watch game shows time wandering in h	on the television. R1 spent nallways, holding a doll, visiting tv and attending activities.			activities. Residents R1, R17, R16 had Activities Assessments comple 4/30/18. The 9 dementia residents	b have eted	

Facility ID: 00586

		AND HUMAN SERVICES			F	FORMA	05/02/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION (X		SURVEY PLETED
		245392	B. WING	;		04/0	5/2018
NAME OF F	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	L C&NC			0 SOUTHEAST FIFTH STREET OOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 744	DMMUNITY HOSPITAL C&NC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 R1's care plan dated 12/23/14, indicated R1 was at risk for impaired social interaction due to memory loss, short attention span, wandering, and easily agitated. R1's goals included R1 would remain at three group activities weekly for 30 minutes, would use leisure time independently, sit with other residents and watch tv in the activity room and socialize at least twice weekly, and hold a doll and visit with staff. R1's interventions included allow R1 decision making for activities, 1:1 visits, coffee groups, take outside when warm, verbal reminders of activity times, attend activities of choice, self propel wheelchair in the hallways, hold stuffed animal or baby, have a soda, and visit or sit with staff. R1's care plan indicated R1 required assistance to activities and staff to sit with her at group activities. R1 was to have an activity calendar in her room, be brought to all music programs, observe active games, and table games. R1's activity documentation indicated the following: -on 4/3/18, R1 spent 180 minutes in an unidentified activity. -on 4/2/18, in the evening R1 spent 120 minutes in a 1:1 visit, coffee group, and observing others. -on 4/2/18, in the afternoon, R1 spent 180 minutes in a 1:1 visit, coffee group, and observing others. -on 4/2/18, in the morning, R1 spent 15 minutes		F	744	well will have activities assessments complete by 5/4/18. The results of the activities assessment have given the Activities Department a direction to properly address dementia care the residents. Household activities such a organizing books, sorting coins and silverware, decorating cookies and assisting with setting of tables. Recreational activities such as flipping through scrapbooks and magazines a dementia appropriate puzzles. Physic activity is limited due to R1, R16, R17 physical function. Education through Medbridge will star second week of May 2018. Proper documentation is also a key fa in the care of our residents. Review of our policy and procedure has shown proper regulatory compliance. Documentation from staff is lacking in quality and is a clear indication that education is needed in this area. An observation from the director of nursing or designee will take place an involve 3 residents per week for 6 wee Observation will include monitoring of resident activities with cognitive impairment. The process will look to ensure proper compliance on meanin activities for our residents. Results w 2 times weekly at IDT and updated at	as g and cal 7 rt the actor of n n hd eeks. f	
	staff -on 4/1/18, in the af in a 1:1 visit, coffee -on 3/31/18, in the a	king with resident/sitting with fternoon R1 spent 360 minutes group, and observing others afternoon R1 spent 360 it, coffee group, and observing			QAPI. An audit of Meditech EMR documenta will take place on 2 residents a week weeks. The documentation will be monitored and updates to IDT will tak place twice weekly and to the QAPI committee.	for 6	

Facility ID: 00586

		AND HUMAN SERVICES			FORM	05/02/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		245392	B. WING		04/	05/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	L C&NC		10 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 744	-on 3/30/18, in the eminutes reading/wri and a 1:1 visit -on 3/30/18, in the r watching tv/movies doll and sitting with Further documentar in these activities of minutes to 360 min Documentation for indicated R1 partici observing others for morning of 4/4/18, I and sitting with staf On 4/2/18, at 6:15 p wandering in the har The outside door al removed from the a observed in the day conversing with oth at that time. On 4/4/18, between was observed to ea hallways on the unit for over a half hour the doll. An activity included making ice On 4/4/18, at 10:00 (NA)-B stated R1 w less since moving to On 4/4/18, at 2:53 p wandering in the har occasionally staff st	evening, R1 spent 100 iting, tv/movies, with children, morning, R1 spent time , coffee group, and holding a staff. tion indicated R1 participated ne to two times daily for 60 utes each time. the afternoon on 4/3/18, pated in coffee group and r 180 minutes, and on the R1 participated in pet visits, f for 90 minutes. o.m. R1 was observed allway and into others' rooms. larm sounded and she was area. At 6:25 p.m. R1 was y area on the unit, smiling and iers. Staff took her to her room n 8:48 a.m. and 10:18 a.m. R1 at breakfast, wander in the t, sit and look out the windows , then hold a doll and talk to on the other unit at that time, e cream. 5 a.m. nursing assistant yandered, but has wandered	F 74	44		

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		AND HUMAN SERVICES				FORM	05/02/2018 APPROVED 0938-0391
STATEMEN	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE	E SURVEY PLETED
		245392	B. WING	i		04/	05/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	L C&NC			0 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 744	In the common acti planting seeds. No with R1 during the o On 4/5/18, at 9:37 a the counter after ea On 4/5/18, at 9:42 a R1 has not had a b unit. H-A stated R1 rooms. H-A stated R1 rooms. H-A stated R1 liked her nails done every so often, or th her. H-A also stat liked her nails done every so often, or th her. H-A stated R1 activities because s On 4/5/18, at 9:56 a stuffed cat and R1 purring. R1 spent th her cat and moving R17's History and F indicated R17's diag advanced Alzheime R17's History and F R17's dementia, an to do interventions encourage her to pa that R17 had been with other residents R17's quarterly MD R17 had severely in daily decision makin hallucinations, and 1-3 days during the	vity area, other residents were pets were observed visiting day. a.m. R1 was sitting quietly at ating her breakfast. a.m. housekeeper (H)-A stated ad day since moving the new wandered less into others' R1 liked her dolls and had ed R1 liked her stuffed cat, e so activities will do her nails ney would do 1:1 visits with usually does not go to group she wanders. a.m. H-A brought R1 her talked to the cat, which was ne morning on the unit, holding about the unit. Physical dated 12/19/17, gnoses included a stroke, er's dementia, and depression. Physical further addressed ad directed nursing to continue to stimulate her, and articipate as able, and noted watching the Price is Right	F	744			

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	TIPLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY MPLETED		
		245392	B. WING			10510040		
	PROVIDER OR SUPPLIER	243332		STREET ADDRESS, CITY, STATE, ZIP		/05/2018		
		L C&NC		10 SOUTHEAST FIFTH STREET COOK, MN 55723	0022			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIO DATE		
F 744	and locomotion off comprehensive ME survey, indicated R important for R17 t was good, otherwis not very important of R17's CAA dated 4 loss/dementia indic impaired cognitive abilities, had sympt disorganized thinki psychosocial well-b CAA which indicate symptoms of depre- address activity pair R17's activity docu following: -on 4/5/18, in the m exercise, visitors, a -on 4/4/18, in the e TV/movies and 1:1 -on 4/4/18, in the f in tv/movies, 1:1 visits in tv/movies, 1:1 visits others for 120 minut -on 4/2/18, in the e tv/movies, 1:1 visits others for 120 minut -on 4/2/18, in the m visits and coffee gr -on 4/1/18, in the a	the unit did not occur. R17's DS, in process during the 17 indicated it was very o go outside when the weather se, activities listed were either or not important at all to R17. /3/18, for cognitive cated R17 had severely skills for daily decision making toms of inattention and had ng. R17's CAA for being referred to the mood ed R17 had no signs or ession. R17's CAAs did not rticipation. mentation indicated the norning R17 participated in ind pet visits for 90 minutes. vening R17 participated in visits for 30 minutes. norning, R17 participated in inutes. atter afternoon, R17 participated sits, coffee group, and the es. arly afternoon, R17 ovies, 1:1 visits coffee group, hers and "zzzzzz" (sleeping) for vening R17 participated in s, coffee group, and observing	F 7	744				

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		AND HUMAN SERVICES				FORM	05/02/2018 APPROVED			
STATEMENT	RS FOR MEDICARE FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	0938-0391 E SURVEY PLETED			
		245392	B. WING _			04/	05/2018			
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-				
соок с	OMMUNITY HOSPITA	L C&NC	10 SOUTHEAST FIFTH STREET COOK, MN 55723							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE			
F 744	(sleeping) for 360 m Further activity doci participated in these for 30 to 360 minute sleeping time, sittin observing others, w A review of R17's a activity calendar for was not taken to gr BINGO on 3/17 and February 2018. On 4/4/18, at 8:47 a the dining room and breakfast. On 4/4/18, at 9:00 a table to sit in front of On 4/4/18, at 9:00 a table to sit in front of On 4/4/18, at 9:42 a room, and at 10:01 the end of the hall t On 4/4/18, at 2:52 p bed. There was an residents planting s On 4/5/18, at 9:35 a the TV on the unit, breakfast. At 9:38 a to go out to sit in fro friends, and R17 sa R17 to her room for On 4/5/18, at 9:51 a unit day area and p closed eyes. R17 sa	ninutes. umentation indicated R17 e activities 1 to 2 times daily, es. Several entries included g in front of the TV, and vithout interaction as activities. activity participation and the r March 2018, indicated R17 oup activities, including d 3/31. The same was true in a.m. R17 was sitting quietly in d was assisted by staff to eat a.m. R17 was moved from the of the TV in the day area. a.m. R17 was brought to her a.m. she was brought down to to sit in the sunlight. o.m. R17 was lying quietly in activity in the day area with seeds. a.m. R17 was sitting in front of with her eyes closed, following a.m. AD-A asked if she wanted ont of the birds with her aid she did. An NA first took	F 74	44						

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/02/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245392	B. WING			04/(05/2018
NAME OF F	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
соок с	OMMUNITY HOSPITA	L C&NC			0 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			BE	(X5) COMPLETION DATE
F 744	unit without taking F On 4/4/18, at 9:58 at displayed physical to cares, but R17's be moving to the new of R17 in the sun for 2 activities staff tend residents who are of activities, to group at have been trying to activities. On 4/5/18, at 11:28 (DON) stated deme and verified there w on 4/4/18, as docur documentation. The residents with deme front of the birds an were not engaging f were trying to revan engaging R1 in acti wandering into othe do more baking and evenings, and the n are very good with I On 4/5/18, at 11:44 stated if residents w activities, he would bird aviary, outside, stated bringing to th and verified they had	a.m. NA-B stated R17 behaviors toward staff during haviors have decreased since unit. NA-B stated they place 25 minutes daily. NA-B stated not to take R17, R1, and those inable to participate fully in activities. NA-B stated the NAs push their attendance in a.m. the director of nursing entia activities were lacking, vere no pet visits on the units nented in R1's activity be DON stated activities for entia often included sitting in d other such activities, which them. The DON stated they inp activities. The DON stated vities would decrease her er rooms. The DON stated they d other activities in the pursing assistants on the unit	F	744	DEFICIENCY)		
	comes to BINGO, a stated pet visits incl	Ind families sit with her. AD-A luded everything, including the prified pets did not visit as					

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		AND HUMAN SERVICES				FORM	05/02/2018 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED		
		245392	B. WING	;		04/05/2018			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
соок с	OMMUNITY HOSPITA	L C&NC			0 SOUTHEAST FIFTH STREET COOK, MN 55723				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 744	residents with demo weekly. AD-A stated training and are sch AD-A stated R1 will likes to sit with the AD-A stated R17 w and they place her that at home. AD-A to church, on bus tr music is noise to he and lotions weekly 1:1 activities are not	stated they make sure entia are seen by activities d staff participate in dementia neduled to attend the training. I hold a doll or her cat, and staff when they are charting. as brought to a quiet place, in the sun because she did stated they do not bring R17 rips or music programs, as er. AD-A stated they do nails for R1 and R17. AD-A stated of scheduled for them.	F 7	744					

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DEPART	FORM APPROVED					
	MB NO. 0938-0391					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245392	B. WING _		04/05/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	L C&NC		10 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG			
F 744	Continued From pa	ge 20	F 74	14		

Facility ID: 00586

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DEPART	FORM APPROVI MB NO. 0938-03	ED				
						<u>91</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		245392	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	240032		STREET ADDRESS, CITY, STATE, ZIP CODE	04/05/2018	
				10 SOUTHEAST FIFTH STREET		
COOKC	OMMUNITY HOSPITA	L C&NC		COOK, MN 55723		
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)	(X5) COMPLETION
PRÉFIX TAG	(EACH DEFICIENCY REGULATORY OR L	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		
				DEFICIENCY)		
F 744		04				
F 744	Continued From pa	ge 21	F 74	14		

Facility ID: 00586

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DEPART	FORM APPROVED					
	MB NO. 0938-0391					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245392	B. WING		04/05/2049	
NAME OF F	PROVIDER OR SUPPLIER	240002		STREET ADDRESS, CITY, STATE, ZIP CODE	04/05/2018	
				10 SOUTHEAST FIFTH STREET		
COOKC	OMMUNITY HOSPITA	L C&NC		COOK, MN 55723		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PRÉFIX		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		
				DEFICIENCY)		
E 744		20				
F 744	Continued From pa	ige 22	F 74	14		

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DEPART	FORM APPROVED					
	MB NO. 0938-0391					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245392	B. WING		04/05/2049	
NAME OF F	PROVIDER OR SUPPLIER	240002		STREET ADDRESS, CITY, STATE, ZIP CODE	04/05/2018	
				10 SOUTHEAST FIFTH STREET		
COOKC	OMMUNITY HOSPITA	L C&NC		COOK, MN 55723		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PRÉFIX		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		
_				DEFICIENCY)		
			l			
F 744	Continued From pa	ige 23	F 74	14		

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DEPART	FORM APPROVED					
		MB NO. 0938-0391				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245392	B. WING _		04/05/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	L C&NC		10 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG			
F 744	Continued From pa	ge 24	F 74	14		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PRO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245392	B. WING			04/05/2018	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
соок с	OMMUNITY HOSPITA	L C&NC			0 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 744	Continued From pa	ge 25	F 7	744			
	diagnoses included depressive disorder R16's History and F indicated R16 resis	lated 3/19/18, indicated R16's altered mental status, major r, and unspecified psychosis. Physical dated 1/26/18, ted much of therapy, most of ed medication; resident is on					
	very little. R16's care plan rev was at risk for imparelated to delusions resident. Interventi to go to bed and ge establish a trusting reassurance and co indicated a risk for in R16 wanted to remain the day, or in a recli often yelled out whe Interventions includ and spouse at mean preferred to sit throw while she's sitting in reminders of activity activities using whe encouragement to a active games. R16 will observe the pict times daily (meals), visits three times we	iewed 2/27/18, indicated R16 ired psychosocial wellbeing that staff wanted to harm ons included R16's preference t up when resident asked, relationship, and provide omfort. The care plan also mpaired social interaction as ain in a certain place most of iner. The care plan noted R16 en seen on a 1:1 basis. ed providing a picture of R16 I table as this was where she ughout the day, offer coffee in the dining area, verbal y times, bringing resident to elchair, table games, attend music programs, and 's goal was specified that she ture of spouse and self, three and resident will accept 1:1					

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		AND HUMAN SERVICES				FORM	05/02/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245392	B. WING	i		04/	05/2018
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	L C&NC			10 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 744	month of February consistently include general activities. If days included comb as TV or movies, 1: observing others, a varying from 20 min activities recorded included 1:1 visit re recorded 53 times (day), observing oth as an activity 38 tim times, observing R ² (though picture obs each meals observe x-ray recorded as a recorded once, pet recorded once, pet recorded once, pet recorded once, pet recorded once, pet recorded once, bet recorded once, bet recorded once, bet recorded once, bet recorded once. April 3, 2018, activit R16 at 1:08 p.m. in in today - TV or Mo Activities Not Listed Time in Activity - 18 documentation reco p.m. listed Activities Movies and Sleepin noted that 180 minu activity staff recordi On 4/4/18, at 2:02 p was interviewed. W experienced chang stated R16 used to	5, 2018, through April 4, 2018, ed combined recording of very Daily recordings for those 59 bined activities participated in 1 visit, coffee group, and sleeping for lengths of time nutes to 360 minutes. All 2/5/18, through 4/4/18, corded 61 times, coffee group (often more than once per ers and/or sleeping recorded nes, TV or movies recorded 49 16's picture recorded twice served to be in front of R16 for ed during survey), took R16 to an activity once, luncheon ty recorded once, visitors auty shop recorded once, nead R16's orded once, and music activity ty documentation record for cluded Activities Participated vies, Coffee Group and Other d of Sleeping for Amount of 80 minutes. Activity or dated April 3, 2018, at 3:27 s Participated in today as TV or ng for 180 minutes. Reviewer utes had not elapsed between	F	744			

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TI	PLE CONSTRUCTION		E SURVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IG		IE SURVEY MPLETED
		245392	B. WING _		04	/05/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
COOKC	OMMUNITY HOSPITA	L C&NC		10 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 744	Continued From pa	ge 27	F 74	4		
	herself, and doesn' the other residents	t usually eat at the same time eat.				
	started working with	o.m. NA-D stated she recently n R16, and had noted that R16 ne day, especially if she had a				
	she visits with R16 response currently used to dance with she was in a wheel joked with R16 and	o.m. NA-C stated that when she didn't get as much as she did previously. NA-C R16 by taking her hands while chair. NA-C stated she had had fun, but R16 doesn't do C noted that R16 slept more decline of aging.				
F 756	Dementia training r include information residents with demo	ed Alzheimer's Disease and naterials provided did not on meaningful activities for entia. iew, Report Irregular, Act On	F 75	6		4/30/18
	CFR(s): 483.45(c)(§483.45(c) Drug Re §483.45(c)(1) The c	1)(2)(4)(5) egimen Review. drug regimen of each resident at least once a month by a				
	§483.45(c)(2) This of the resident's me	review must include a review edical chart.				
	irregularities to the facility's medical dir and these reports n	oharmacist must report any attending physician and the rector and director of nursing, nust be acted upon. lude, but are not limited to, any				

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	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIDI		O. 0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:	` '			OMPLETED
		245392	B. WING			4/05/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
соок с	OMMUNITY HOSPITA	L C&NC			0 SOUTHEAST FIFTH STREET COOK, MN 55723	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 756	(d) of this section fc (ii) Any irregularities during this review n separate, written re attending physician director and directo minimum, the resid and the irregularity (iii) The attending p resident's medical r irregularity has bee action has been tak be no change in the physician should do the resident's medical \$483.45(c)(5) The f maintain policies ar drug regimen review limited to, time fram the process and ste when he or she ider requires urgent action This REQUIREMEN by: Based on interview facility failed to ensu- recommendations to of nursing (DON) an of 5 residents (R9, addition, the facility	or an unnecessary drug. Is noted by the pharmacist must be documented on a port that is sent to the and the facility's medical r of nursing and lists, at a ent's name, the relevant drug, the pharmacist identified. hysician must document in the record that the identified n reviewed and what, if any, the naddress it. If there is to a medication, the attending bocument his or her rationale in cal record. Facility must develop and nd procedures for the monthly w that include, but are not hes for the different steps in eps the pharmacist must take ntifies an irregularity that on to protect the resident. NT is not met as evidenced w and document review, the	F 7	756	Upon surveyor review of our current process for pharmacy recommendations we found that we were not in compliance with the regulations and closing the loop on physician follow up. While survey team was at the Cook Care Center we changed our procedure as follows:	e
	of 5 residents (R3) medications. Findings include:	reviewed for unnecessary dicated R9's diagnoses			 While surveyors were on site we change our process and procedure to ensure the physician was aware of pharmacy recommendations and director of nursin or designee was following up with the compliance. R9, R27, R6, R6, R3, R16 were found to 	e g

Facility ID: 00586

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CENTE		AND HUMAN SERVICES				APPROVE 0938-039
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		245392	B. WING		04/0	05/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	L C&NC		10 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 756	hypothyroidism, and disease. R9's quarterly Minir 1/17/18, indicated F mood symptoms, h depression and pai R9 received antips antidepressant, ant medications during R9's Physician Orde medications that ind pain medications in medications, antico medications, antico	d atherosclerotic heart mum Data Set (MDS) dated R9 was cognitively intact, had allucinations, anxiety, n. R9's MDS further indicated cychotic, antianxiety, icoagulant, diuretic, and opioid the assessment period. ers included orders for cluded dementia medications, icluding opioids, antipsychotic agulant medications, diuretic d medications, blood pressure	F 75	 have no negative effects in their h chart audit with documentation an signs was reviewed along with phy updates. *Pharmacy department (on site) m recommendations to physicians be best-practice for resident care. The place prior to physician monthly recresidents. *Pharmacy recommendation is plawith rounding documentation for the physician to view. We will continue practice of the RN nurse manager rounding with physician, or nurse designee if she is unavailable. *Physician will make their desired changes or not based on their best-practice care for the resident resident and family discussion. *Physician will document in Medite EMR or residents Progress Note will include the pharmacy 	d vitals /sician nakes ased on nis takes unds of aced ne e the and acch	
	review and follow u pharmacy consultant reviewed and follow but lacked review b director. R27's Face Sheet in included acute kidn wheezing, and term R27's annual MDS was cognitively inta depression, depres	p by the physician. R9's nt recommendations were ved up on by R9's physician, by the DON and the medical ndicated R27's diagnoses rey failure, anemia, pain, ninal atrophy of the kidney. dated 1/14/18, indicated R27 ret, had mild symptoms of sion, pain affecting sleep and received an antidepressant		recommendations and how the ph adjusted a medication regimen or *Agenda item has been added to pharmacy recommendations. Thi a standing agenda item. The rour take place that week will be monit physician follow up to the recommendations and will not cor IDT list until documentation of recommendation is complete in th and physical or Progress Note. The director of nursing or designe monitor and audit all pharmacy recommendations and physician f for completeness and regulatory compliance. The IDT meetings ar	not. DT as s will be nds that ored for ne off e history e will ollow up	

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		HAND HUMAN SERVICES E & MEDICAID SERVICES				FORM	05/02/2018 APPROVEE 0938-039
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVE COMPLETED	
		245392	B. WING	;		04/	05/2018
	PROVIDER OR SUPPLIER		1	10	TREET ADDRESS, CITY, STATE, ZIP CODE 0 SOUTHEAST FIFTH STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ı ıx	OOK, MN 55723 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	antidepressant me blood pressure me medications. R27's monthly con included several re review and follow pharmacy consulta reviewed and follo	age 30 edications, pain medications, edications, and diuretic asultant pharmacist reviews ecommentations requiring up by the physician. R27's ant recommendations were wed up on by R27's physician, by the DON and the medical	F	756	result updates will be given at facilit QAPI. The director of nursing is responsit compliance of this regulation.	•	
	diagnoses of high cholesterol, and de included antipsych antidepressant me medications. R6's monthly cons included recomme follow up by the ph consultant recomme followed up on by lacked review from R3's quarterly MD2 diagnoses of high	S dated 3/13/18, identified blood pressure, high epression. Medications otic medications, edications, and diuretic sultant pharmacist reviews endations requiring review and hysician. R6's pharmacy nendations were reviewed and R6's physician; however, in the DON and the MD. S dated 1/6/18, identified blood pressure and high					
		der Sheet dated 3/27/18, or blood pressure medications					

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		AND HUMAN SERVICES				FORM	: 05/02/2018 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DAT	E SURVEY IPLETED
		245392	B. WING	i		04/	05/2018
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
соок с	OMMUNITY HOSPITA	L C&NC			10 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 756	including Norvasc, <i>J</i> The Physician Orde Lipitor for high chold R3's pharmacy med following recomment - 11/24/17, the consu- recommended the p frequency of R3's b - 12/7/17, the consu- recommended check (lab to check choles appropriate therapy was completed Oct The physician did n the 12/7/17, consult recommendations in recommendations in recommendatio	Apresoline, Zestril, Lopressor. er Sheet identified an order for esterol. dication reviews identified the indations: sulting pharmacist physician to clarify the blood pressure checks. ulting pharmacist cking R3's fasting lipid panel sterol levels) to ensure 7. The last fasting lipid panel tober of 2016. not address the 11/24/17, and ting pharmacist in writing, nor were the reviewed by the DON or MD. o.m. registered nurse (RN)-D a year and half since R3 had a ed. The physician failed to ne lipid panel or justification for ddition, the physician failed to R3's blood pressure should be of have a specific order for pressure checks and received s needed. The current process ult recommendations included inpleting the recommendations rd. They were then printed and a designee to place in the g forms to address. There was ss to ensure the physician	F	756			

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		AND HUMAN SERVICES				FORM	05/02/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245392	B. WING			04/0	05/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	L C&NC			0 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	he did not review the recommendations at them either. The DO to get the physician recommendations. process to ensure the recommendations. At 2:58 p.m. the con- stated she sends the recommendations the needed an immedia she would go to the stated she felt she get recommendations, 90 percent of them. The facility policy CC dated 2017, directed discovered an irreg in the residents me forwarded to the phe irregularities and re added to a spread as would be used for for recommendations of for completion and the physician. A rep end of the month. The irregularities and re sent to the director director for review. R16's Face Sheet of diagnoses that inclu- edema, essential hy (blood potassium left)	ie pharmacy consults and the MD did not review ON stated it was a challenge is to address all the identified There was not a current the physician addressed the insulting pharmacist (CP) the irregularities and to the DON and MD. If she ate response from a physician, to the DON and MD. If she ate response from a physician, e physician herself. The CP gets a timely response on her and the physician's approve the dwhen the pharmacist ularity it would be documented dical record and printed and hysician for review. All commendations would be sheet in the pharmacy, which	F7	756			

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		AND HUMAN SERVICES				FORM	05/02/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENT	CIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245392	B. WING			04/	05/2018
NAME OF PROVIDER OR	SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
COOK COMMUNITY	HOSPITA	L C&NC			0 SOUTHEAST FIFTH STREET COOK, MN 55723		
PREFIX (EACH I	DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
9/15/17, in Recomme of diuretic February 2 R16's con- dated 10/1 Septembe reduction appropriat level due t February 2 R16's con- 11/10/17, i October: level as fu level as fu level is fro R16's MD 12/22/17, potassium On 4/5/18 pharmacis recommer nursing. D the physic would exp stated that DON and pharmacis action the recommer doing the consultant	sultant ph included: and check therapy f 2017. sultant ph 16/17, inc or docum e. Recor o diuretic 2017. sultant ph included: Recomm rosemide m Februa notes da lacked ar level. , at 2:25 p indation ge uring the ian sees ect the M t the facili other nur physiciar notations, monthly r pharmad	harmacist monthly review note Medication review for August: king potassium level because for edema. Last level was in harmacist monthly review duded: Medication review for apine due for a gradual dose tentation why it is not mmend rechecking potassium c use; last level is from harmacist monthly review note Medication review for end rechecking a potassium a is expected to lower it. Last	F7	756			

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ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI	E CONSTRUCTION (X3		SURVEY	
ID PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COMF	PLETED	
		245392	B. WING			04/0)5/2018	
IAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
соок с	OMMUNITY HOSPITA	L C&NC) SOUTHEAST FIFTH STREET OOK, MN 55723			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETIO DATE	
F 756	Continued From pa	ge 34	F 7	'56				
		sician responds to the cist's recommendations.						
		Error Rts 5 Prcnt or More	F 7	'59			5/15/18	
SS=D	CFR(s): 483.45(f)(1							
	§483.45(f) Medicati The facility must en							
!	percent or greater;	cation error rates are not 5						
	by:							
		tion, interview, and document			The Cook Hospital and Care Center h			
		ailed to ensure medications /ithout a physician's order for 2			a medication administration policy tha was, after review, found to be lacking			
	of 9 residents (R11	, R19) observed for			addressing the component of crushing	g of		
	medication adminis	tration. This resulted in a te of 14%.			medication together for our residents. The policy did have proper medication	า		
	Findings include:				administration technique. Competent is the goal of the facility for quality resident care.	Stan		
	R11's History and F	Physical dated 7/10/17,			In review of resident vitals signs, nurse	е		
		gnoses included chronic pain,			documentation and physician progres	s		
	macular degenerati	on and esophageal strictures.			note, no ill effects on R11 when medication was crushed together or w	/ith		
		cian Orders dated 2/23/18,			R19 when eye drops were given witho	out		
		Occuvite with Lutein (vitamin			proper hand hygiene. Physician order			
		th) one tab po (by mouth) (pain medication) 50			have been obtained on R11 and R19. an immediate resident audit, 10 reside			
	milligrams (mg) po	three times daily, Aleve			receive their medication crushed. A			
		nflammatory) 220 mg po twice			physician order is in place to crush the medications on all residents checked.			
	medications.	lack directives to crush			an immediate audit 5 other residents			
	On 1/2/19 at 5:27 -	m during observation of			receive eye drops. No illness has bee			
		o.m. during observation of egistered nurse (RN)-A			found on any of those residents after a chart review and audit of vital signs, n			
	crushed R11's napr	oxen sodium (Aleve),			note and physician progress note.			
	Occuvite, and tram	adol (Ultram) medications			The Cook Care Center has implement	nted		

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	OF DEFICIENCIES		(¥2) MIII TI	PLE CONSTRUCTION		E SURVEY
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		G		PLETED
		245392	B. WING		04/	05/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
соок с		AL C&NC		10 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 759	Continued From pa	age 35	F 75	9		
	prior to administrat administered the c applesauce to R11 medications crushi an order for crushi the medications we knew. On 4/2/18, at 5:59 have an order to co On 4/3/18, at 11:43 medication pass, F part, they give R11 stated R11 does be sometimes they cr depending on his s this morning they c gave them in 3 spo administer R11 tra which he took with R19's History and indicated R19's dia and osteopenia (bo related fractures. R19's signed Phys included orders for mg po four times c physician orders la medications. On 4/3/18, at 11:54 acetaminophen, ar	tion of these medications. RN-A rushed medication in . RN-A stated R11 has ed, but did not know if R11 had ng medications. RN-A stated ere okay to crush as far as she p.m. RN-A verified R11 did not rush medications. B p.m. during observation of RN-B stated that for the most 's medications whole. RN-B etter as the day goes on, but ush his medications, swallowing ability. RN-B stated crushed R11's medications and bonfuls. RN-B proceeded to madol whole in applesauce, out difficulty. Physical dated 6/28/17, agnoses included Alzheimer's one loss) with a history of ician Orders dated 3/28/18, Tylenol (acetaminophen) 650 laily for arthritis. R19's toked orders to crush		a new competency program that effect 5/15/18 for nursing staff ar nurse aide group. Staff will be en- on this competency during the 1s May 2018. It will consist of best- competency in physical, mental a psychosocial well-being. Nursing be trained on proper medication administration including but not li administration of medication that be crushed, physician orders, ind crushing and administration of a medication, proper hand hygiene administration of ophthalmic drop residents. Training for nursing si complete by May 15 2018. Annu competency checklist in a re-van has been implemented for start of May 15 2018. Competency inclu- specific skills for resident care, a evaluation of the skill, whether th member demonstrated the skill of further training, the method of ev (demonstration, observation, writ or verbal test) and staff member verified competency and date. Nurse staff education will take pl 2nd week of May 2018. The edu will involve administration of medi- and proper hygiene during medic pass. Best-practice will be used education and compliance of reg standards will be re-enforced. Observation of medication admir will be performed 3 times weekly	d the ducated st week of practice and staff will mited to needs to lividual and os for aff will be al oped for late of des n e staff r needs aluation ten test who ace the cation for staff ulatory istration	
	which he took with R19's History and indicated R19's dia and osteopenia (bo related fractures. R19's signed Phys included orders for mg po four times of physician orders la medications. On 4/3/18, at 11:54 acetaminophen, ar applesauce to R19 had an order to cru	out difficulty. Physical dated 6/28/17, agnoses included Alzheimer's one loss) with a history of ician Orders dated 3/28/18, Tylenol (acetaminophen) 650 laily for arthritis. R19's icked orders to crush 4 a.m. RN-B crushed R19's nd administered it in 0. RN-B incorrectly stated R19		evaluation of the skill, whether the member demonstrated the skill of further training, the method of ev (demonstration, observation, write or verbal test) and staff member verified competency and date. Nurse staff education will take pl 2nd week of May 2018. The edu will involve administration of medic and proper hygiene during medic pass. Best-practice will be used education and compliance of reg standards will be re-enforced. Observation of medication admir	e staff r need aluatic ten tes who ace the cation for sta ulatory istratic for 6 2 time API.	ls on st e ff y on

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	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT	<u>0938-039</u> E SURVEY IPLETED
		245392	B. WING		04/	05/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
соок с		AL C&NC		10 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 759	Continued From pa	age 36	F 759			
	(DON) verified me crushed without a	dications were not to be physician's orders.		weekly for 6 weeks to check Medit EMR for compliance and accuracy documentation of medication		
	Long Term Care da to crush pills when physician orders, n pharmacist, and dr procedure further i crushed together u	Administration of Medication in ated 4/13/17, directed nursing necessary according to nanufacturer's information, rug reference. The policy and ndicated medications may be inless contraindicated by anufacturers information or and standards		administration. These results will b updated at IDT 2 times a week and facility QAPI. The director of nursing is responsil compliance of this regulation.	l at	
F 880 SS=F		n & Control	F 880			5/15/18
	infection prevention designed to provid comfortable enviro	stablish and maintain an n and control program e a safe, sanitary and nment and to help prevent the ransmission of communicable				
	program. The facility must es	n prevention and control stablish an infection prevention m (IPCP) that must include, at lowing elements:				
	reporting, investiga and communicable staff, volunteers, vi providing services arrangement base	stem for preventing, identifying, ating, and controlling infections diseases for all residents, isitors, and other individuals under a contractual d upon the facility assessment ng to §483.70(e) and following standards:				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		TE SURVEY MPLETED	
			A. BUILDII	NG				
		245392	B. WING			•	/05/2018	
IAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP COD COUTHEAST FIFTH STREET			
COOK C	OMMUNITY HOSPITA	L C&NC						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE	
F 880	Continued From pa	ige 37	F 8	80				
		en standards, policies, and program, which must include, o:						
	(i) A system of surv possible communic	eillance designed to identify						
	communicable dise	ity; nom possible incidents of ease or infections should be						
	to be followed to pr	ansmission-based precautions event spread of infections;						
	resident; including (A) The type and d	isolation should be used for a but not limited to: uration of the isolation, e infectious agent or organism						
	involved, and (B) A requirement t	hat the isolation should be the						
	circumstances.	sible for the resident under the	!					
	must prohibit emplo disease or infected contact with resider contact will transmi	byees with a communicable skin lesions from direct nts or their food, if direct						
	by staff involved in	direct resident contact.						
		stem for recording incidents facility's IPCP and the aken by the facility.						
		ndle, store, process, and as to prevent the spread of						

Facility ID: 00586

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			()(0) 14:		OMB NO.		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED	
		245392	B. WING _		04/	05/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE		
соок с	OMMUNITY HOSPITA	L C&NC		10 SOUTHEAST FIFTH STREET COOK, MN 55723			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 880	Continued From pa	age 38	F 88	30			
	IPCP and update the This REQUIREMEND by: Based on observative review the facility fathandwashing and g for 1 of 1 residents cares. In addition, the appropriate hand he prevent cross contation (R11) observed for addition, the facility analyze the infection and patterns to red infections. This had residents residing i Findings include: On 4/4/18, at 9:31 apersonal cares, num R4's hi-lo bed and her wheelchair to he disposable gloves. incontinent brief and wet, removed the bic cares. NA-D placed and put the plastic	duct an annual review of its heir program, as necessary. NT is not met as evidenced tion, interview, and document ailed to ensure proper glove usage was implemented (R4) observed for personal he facility failed to use ygiene and techniques to amination for 1 of 1 resident eye drop administration. In failed to comprehensively on surveillance logs for trending uce the occurrence of the potential to affect all 26 n the facility. a.m. during observation of rsing assistant (NA)-D raised used a lift to transfer R4 from er bed. NA-D put on NA-D checked R4's d determined the brief was vrief and provided perineal d the wet brief in a plastic bag bag in the trash can near the ffed gloves and immediately		In a review of the Cook O Infection Prevention Plan that there is a lack of writ infections which would ide concerns. This policy wa updated to add a process Infection Preventionist wil resident infection to allow response as needed. We the policy on hand hygien on resident cares and me administration. In our rev found that the process an in place, however it was r followed by staff. In review of resident char signs, nurse notes and pf we have found no ill effect R4 from improper hand h administration of eye drop For the more timely moni infections on our resident a standing agenda item to twice weekly. Infection pf will monitor and trend all or continuing and antibiot	policy we agree ten analysis of entify trends or s immediately by which the I follow trends on more timely e also reviewed e. We focused edication riew we have d procedure are not being ts including vital hysician rounds ts on resident ygiene or during os to R11. toring of s we have added o IDT meeting revention nurse infections, new		
	pulled R4's clothing adjusted and lower with pillows betwee the plastic bag with from the trash can, replaced the plastic replaced the sling of	g up to her waist. NA-D ed the bed, and positioned R4 in her legs. R4 then removed the soiled incontinent brief set it on the floor, and bag with a clean one. NA-D on the chair and then went to washed her hands with soap		usage. Monthly an updat IDT for any unusual trend residents. Infection preve audit all resident docume infections and antibiotics. will be given to QAPI tear well as the monthly trends weekly updates at IDT on	e will be given to s seen in our ention nurse will ntation on These trends n quarterly as s and twice		

Facility ID: 00586

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	05/02/2018 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3) DATI	E SURVEY PLETED	
		245392	B. WING_		04/	05/2018	
	PROVIDER OR SUPPLIER	L C&NC	STREET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTHEAST FIFTH STREET COOK, MN 55723				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR	SHOULD BE	(X5) COMPLETION DATE	
F 880	completed, NA-D co hands after she cou R4. NA-D stated th sanitize her hands (completion of pers she did not want to NA-D stated she for she did not carry sa stated she did not h trained to sanitize of after removing a so On 4/5/18, at 10:11 nursing (ADON) sta wash their hands a and before moving stated that she had available to staff fo saw a staff membe would stop and edu ADON restated her be washed after re moving on to other The facility Hand H 2018, directed han- before and after dir after gloving, after hygiene for residen R11's signed physic included orders for instill 1 drop into bo On 4/3/18, at 11:43 medication pass. R medications and ey RN-B did not wash	confirmed she did not wash her mpleted incontinence cares for nat she usually did not wash or until the end of the process sonal cares) with R4 because leave R4 with her bed raised. orgot to wash her hands, and anitizer in her pocket. NA-D know whether she had been or wash her hands immediately biled incontinent brief. a.m. the assistant director of ated she expected staff to fter removing soiled gloves, on to other tasks. The ADON I pocket sized hand sanitizers r use. The ADON stated if she er fail to wash their hands, she ucate staff in the moment. The r expectation that hands are to moving soiled gloves, before tasks. lygiene policy dated January d hygiene was to be performed rect contact with a resident, engaging in acts of personal its, and other situations. cian orders dated 2/23/18, Artificial Tears eye drops, oth eyes four times daily.	F 8	80 Infection prevention nurse wistaff starting May 1 2018 in a hand hygiene training and redemonstration. This re-eduction complete the second week of all staff given the training. At infection prevention education continue through the infection nurse. Infection prevention reduction continue through the infection nurse. Infection prevention reducing resident care on the prompliance of hand hygiene. take place for 6 weeks. The be updated weekly at IDT an QAPI. Director of nursing or design medication passes per week ophthalmic drop placement from pliance of proper hand hompliance of proper hand hompliance of protect of nursing is rest the regulatory compliance of processes.	a hands on turn cation will be f May to have nnual n will n prevention nurse will er week roper Audits will d at facility ee will audit 2 including or ygiene and audits will be at IDT and		

If continuation sheet Page 40 of 43

		AND HUMAN SERVICES				FORM	05/02/2018 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245392	B. WING			04/	05/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	L C&NC			0 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	medication first. RN open, touching the ungloved left hand, artificial tears into the tip of eye drop both repeated the practic touching the tip of the eyelid. RN-B returns manipulated items of cart drawer. When during eye drop adre wore gloves, "Some eye drops in the me documented on the washing or sanitizin administration of ey resident's eyes, RN sanitizes her hands documenting on the should have sanitize eye drop administration (DON) verified nurs glove prior to admin instill eye drops with bottle to the eye lid. should remove glow hands immediately drops. The facility policy H directed hand hygie after each resident soap and water prio prior to passing out resident medication	A-B then held R11's right eye outside of his eyelid with her and administered a drop of he right eye while touching the e to R11's eyelid. RN-B ice on R11's left eye, again he eye drop bottle to R11's ed to the medication cart, on the cart, and opened the asked about wearing gloves ministration, RN-B stated she etimes." RN-B put away the edication cart, and computer. When asked about ng hands following ye drops and touching a I-B stated she washes or after she is done e computer. RN-B stated she ed her hands right away, after ation. a.m. the director of nursing ses should wash hands and histration of eye drops, then hout touching the eye drop . The DON stated nurses yes and sanitize or wash after administration of eye land Hygiene revised 1/18, ene to be done before and contact, and wash hands with or to setting up medication and medication, and in between	F8	80			

		AND HUMAN SERVICES				FORM	05/02/2018 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE	E SURVEY PLETED
		245392	B. WING	i		04/0	05/2018
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
соока	OMMUNITY HOSPITA	L C&NC			10 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	included three urina results were not inc infection, and one of lacked a written and include if the urinar or if interventions we urinary tract infection The January 2018, included four urinar organisms causing E. coli and one E. fa written analysis of t urinary tract infection interventions were in tract infections. The February 2018 included one urinar coli, one skin infect pneumonia. The fac of the infections. On 4/5/18, at 1:32 p (the facility infection January of 2018 the logged infections. F all organisms for cu- reported only the nu- the infections in the fac analysis was to lool infections, and if an changes in their sys The facility Infection	ary tract infections (culture cluded on the log), one scalp case of pneumonia. The facility alysis of the infections to y tract infections were related, rere implemented to reduce	F	380			

If continuation sheet Page 42 of 43

		AND HUMAN SERVICES				FORM	05/02/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245392	B. WING	;		04/	05/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	L C&NC			0 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	The policy did not id	age 42 hter personnel as appropriate. dentify completing a written identify trends or concerns.	F	880			

Facility ID: 00586

If continuation sheet Page 43 of 43

		AND HUMAN SERVICES & MEDICAID SERVICES	书	53	1020210	FORM	05/01/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMI	E SURVEY PLETED
		245392	B. WING			04/0	04/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
соок со	OMMUNITY HOSPITA	L C&NC		· ·	0 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS	ĸ	000			
	FIRE SAFETY						
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.					
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATION HAS	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE BEEN ATTAINED IN TH YOUR VERIFICATION.					
	Minnesota Departm Fire Marshal Divisio Cook Hospital C & compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F	Survey was conducted by the nent of Public Safety, State on. At the time of this survey NC was found not in a requirements for participation at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC), Health Care.					
		E AN EPOC, A PAPER COPY CORRECTION IS NOT			EPOC		
	PLEASE RETURN CORRECTION FOI DEFICIENCIES (K-	R THE FIRE SAFETY					
LABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
Electroni	cally Signed						04/27/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '			TE SURVEY MPLETED
				G 01 - MAIN BUILDING 01		
		245392	B. WING			/04/2018
				STREET ADDRESS, CITY, STATE, ZIP C 10 SOUTHEAST FIFTH STREET	ODE	
COOKC	OMMUNITY HOSPITA	AL C&NC		COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
K 000	STATE FIRE MAR 445 MINNESOTA ST. PAUL, MN 551 By e-mail to both: Marian.Whitney@s and Angela.Kappenma THE PLAN OF CC DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the defice 2. The actual, or pr 3. The name and/or responsible for cor prevent a reoccurr Cook Hospital C & partial basement. constructed in 196 2005, and 2017. T the 1966, 2000, an (111) construction. determined to be c	RE INSPECTIONS SHAL DIVISION STREET, SUITE 145 101-5145, or state.mn.us n@state.mn.us PRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done	К 00	0		
	including the 2017 prior to July 5, 201 building for inspect was inspected as 7	which had plans approved 6 were considered existing tion purposes and the facility				

If continuation sheet Page 2 of 5

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		E SURVEY
D PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G 01 - MAIN BUILDING 01	COM	PLETED
		245392	B. WING		04/	04/2018
AME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	14	
оок с	OMMUNITY HOSPITA	AL C&NC		10 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
K 000	Continued From pa	age 2	к 00	0		
		spaces open to the corridor, or automatic fire department				
		censed capacity of 28 beds of 28 at the time of the survey.				
K 712	The requirement at is NOT MET. Fire Drills	t 42 CFR, Subpart 485.623 (d)	K 71	2		4/27/18
	CFR(s): NFPA 101			-		
	signal and simulatic conditions. Fire dril unexpected times us least quarterly on e with procedures an established routine between 9:00 PM a	ne transmission of a fire alarm on of emergency fire Ils are held at expected and under varying conditions, at each shift. The staff is familiar ad is aware that drills are part of e. Where drills are conducted and 6:00 AM, a coded y be used instead of audible				
	19.7.1.4 through 19 This REQUIREME by:	NT is not met as evidenced			·	
	interview, it was de to conduct several the NFPA 101 "The edition (LSC) section 12-month period. T affect 28 of 28 resid	of reports, records and staff etermined that the facility failed fire drills in accordance with a Life Safety Code" 2012 on 19.7.1.6, during the last This deficient practice could dents, as well as an ber of staff, and visitors.		Fire drills were added to the Ma Supervisor's calendar for the yea will be performed on those dates supervisor will not let anything el interfere with the fire drill proces QAPI will be started and monitor quarter for 2018. Fire drills required LSC have been performed.	ar. They s and lse s. red every	

Event ID: 310F21

Facility ID: 00586

If continuation sheet Page 3 of 5

	OF DEFICIENCIES	E & MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION		0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G 01 - MAIN BUILDING 01		IPLETED
		245392	B. WING		04/	04/2018
NAME OF	PROVIDER OR SUPPLIER	J.		STREET ADDRESS, CITY, STATE, ZIP CODE		
соок с	OMMUNITY HOSPIT	AL C&NC		10 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
K 712	Continued From pa	age 3	K 71	2		
	on 04/04/2018, du fire drill documenta Maintenance Supe	ween 11:30 a.m. to 2:30 p.m. ring the review of all available ation and interview with a ervisor revealed that the facility overnight shift fire drill in the				
	Maintenance Supe	uilding System Categories	K 90	11		5/25/18
	Building systems a 1 through 4 require Categories are det					
	by:	NT is not met as evidenced		The Maintenance Supervisor		
	facility has failed to current facility Risk with the NFPA 99 " 2012 edition section could affect 28 of 2	ation and staff interview, the provide a complete and Assessment in accordance Health Care Facilities Code" on 4.1. This deficient practice 8 residents, as well as an ober of staff, and visitors.		The Maintenance Supervisor v complete a Risk Assessment in accordance with the 2012 editi 4.1. LSC NFPA 99 chapters 10 12. A QAPI has been initiated. An auditing will be performed.	n on section), 11 and	
	Findings include:					

Event ID: 310F21

Facility ID: 00586

If continuation sheet Page 4 of 5

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MU		ONSTRUCTION		E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			- MAIN BUILDING 01	CON	PLETED
		245392	B. WING	_			04/2018
AME OF I	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
оок с	OMMUNITY HOSPITA	AL C&NC			OUTHEAST FIFTH STREET DK, MN 55723		
(X4) ID			ID		PROVIDER'S PLAN OF CORREC		(X5) COMPLET
REFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)		DATE
K 901	Continued From pa	age 4	КS	001			
		ween 11:30 a.m. to 2:30 p.m.					
and an inte it was reve		ing the documentation review ith the Maintenance Supervisor					
	it was revealed that	t the facility's risk assessment					
		account for all of the systems ntified in chapter 10 and 11 of					
	the NFPA 99 "Heal	th Care Facilities Code" 2012					
	edition.						
	This deficient cond	ition was confirmed by the					
	Maintenance Supe						
CMS-25	67(02-99) Previous Versions	S Obsolete Event ID: 310F2	1	Facility	ID: 00586 If co	ntinuation sh	oot Dago

PRINTED: 05/01/2018



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 20, 2018

Ms. Teresa Debevec, Administrator Cook Community Hospital C&NC 10 Southeast Fifth Street Cook, MN 55723

Re: State Nursing Home Licensing Orders - Project Number S5392028

Dear Ms. Debevec:

The above facility was surveyed on April 2, 2018 through April 5, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

Cook Community Hospital C&NC April 20, 2018 Page 2

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Teresa Ament, Unit Supervisor, at (218) 302-6151 or teresa.ament@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Metatylan

Michaelyn Bruer, Enforcement Specialist Minnesota Department of Health Health Regulation Division Program Assurance Unit phone 651-201-4117 fax 651-215-9697 email: <u>michaelyn.bruer@state.mn.us</u>

cc: Licensing and Certification File

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED
		00586	B. WING		04/0	5/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	L C&NC 10 SOUTH COOK, M	HEAST FIFTH N 55723	H STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defict herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance.	nether a violation has been				
		ment of a fine even if the item uring the initial inspection was				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
Vinnesota D _ABORATOR`	epartment of Health Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
	ically Signed					04/30/18

6899

If continuation sheet 1 of 35

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00586	B. WING		04/	05/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	AL C&NC	HEAST FIFTH	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 000	Department of Hea you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th corrected prior to e Minnesota Departm On 4/2/18, through Department's staff the following correct Please indicate in y correction that you and identify the dat Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag n column entitled "ID statute/rule out of co "Summary Statement and replaces the "T correction order. Th findings which are after the statement evidence by." Follo are the Suggested	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for a indicate in the electronic cess, under the heading ie date your orders will be lectronically submitting to the nent of Health. 4/5/18, surveyors of this visited the above provider and ction orders are issued. your electronic plan of have reviewed these orders, ie when they will be completed nent of Health is documenting of Correction Orders using ag numbers have been sota state statutes/rules for humber appears in the far left of Prefix Tag." The state compliance is listed in the ent of Deficiencies" column fo Comply" portion of the his column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and				
	FOURTH COLUM "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				

	Ita Department of He	(X1) provider/supplier/clia		E CONSTRUCTION (X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
00586		00586	B. WING		04/05/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
соок с	OMMUNITY HOSPITA	L C&NC 10 SOUT	HEAST FIFT N 55723	H STREET	
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	
2 000	Continued From pa	ge 2	2 000		
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.			
2 375	MN Rule 4658.0200 Residents;Visitors) Subp. 1 Policies Concerning	2 375		5/15/18
	provide access to a guardians, and to a provides health, soo religious services to resident's right to do any time. A nursing access to others wh the resident's conse restrict visits when	A nursing home must resident by relatives and ny entity or individual that cial, legal, advocacy, or o the resident, subject to the eny or withdraw consent at g home must also provide no are visiting the resident with ent. A nursing home may the visits pose a health or dent or otherwise violate a			
	by: Based on interview facility failed to allow during an influenza	ent is not met as evidenced and document review, the w residents visitation rights outbreak. This had the I 26 residents residing in the		Corrected	
	Findings include:				
	through 3/1/18, ider influenza-like symp residents had a cor The first confirmed 2/26/18. The Line L were placed on pre-	Illness Line List from 2/25/18, htified 11 residents with toms. Three of the 11 firmed Influenza A diagnosis. case of Influenza A was on ist identified all 11 residents cautions, with the last day of utions being 3/8/18. The			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00586		B. WING		04/05/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	AL C&NC	THEAST FIFTH MN 55723	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 375	Continued From pa	age 3	2 375			
	facility closed their through 3/12/18.	doors to visitors from 2/26/18,				
	stated she had to s because of influenz facility would not al family members ha facility did not discu	p.m. R25 was interviewed, and tay in her room for five days za. Further, R25 stated the low any visitors, and then id complained. R25 stated the uss with the residents about it told the residents they were visitors.				
	stated the facility ca not allowing any vis influenza outbreak was not sure how lo	a.m. family member (FM)-A alled and notified her they were sitors, because there was an in the facility. FM-A stated she ong the restrictions lasted, but ed and let her know when she ty again.				
	R2, R9, R14, R25, administration shut including family du	the resident council meeting and R27, all stated the facility down the facility to all visitors ring an influenza outbreak. R2 ome without visitors.	5			
	stated the facility pe when there was an been done in the pa residents were noti visitation; however and then the restrict stated the restriction	a.m. registered nurse (RN)-D olicy directed to restrict visitors influenza outbreak; and it had ast. Further, the families and fied of the restrictions on a few families became upset, ctions were removed. RN-D on on visitors was not well hilies, and the facility was trying ents.	5			
	stated he did not ev	lirector of nursing (DON) ven question the closing of the le stated the facility infection				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		00586	B. WING		04/05/2018	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
COOK C	OMMUNITY HOSPITA		HEAST FIFTH IN 55723	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 375	Continued From pa	age 4	2 375			
		e restrictions in place. After d, the restrictions were lifted.				
	preventionist), state thought it would be visitation to the faci influenza outbreak.	p.m. RN-C (the facility infection ed she did some research, and appropriate to restrict ility during the facility's RN-C stated she did not take sident's rights to have visitors.				
	dated 1/10/17, iden right, and the care	isitation in Long Term Care tified the resident had the center must provide immediate shes to family and non-family	9			
	SUGGESTED MET	THOD OF CORRECTION:				
	designee could dev policies and proceed rights to visitation is The Director of Nur educate all appropri procedures. The Director of Nur	rsing and/or administrator or velop, review, and/or revise dures to ensure residents' s upheld. rsing or designee could riate staff on the policies and rsing or designee could systems to ensure ongoing				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one	•			
2 915	MN Rule 4658.052	5 Subp. 6 A Rehab - ADLs	2 915			4/30/18
	comprehensive res home must ensure A. a resident is	of daily living. Based on the ident assessment, a nursing that: given the appropriate vices to maintain or improve				

STATE FORM

310F11

If continuation sheet 5 of 35

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00586	B. WING		04/05/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	AL C&NC	HEAST FIFT IN 55723	H STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
2 915	abilities in activities deterioration is a n the resident's cond part, activities of da resident's ability to (1) bathe, dre (2) transfer ar (3) use the toi (4) eat; and (5) use speec	s of daily living unless ormal or characteristic part of lition. For purposes of this aily living includes the : ss, and groom; nd ambulate;	2 915			
	by: Based on observat review, the facility f a timely manner to reviewed for comm	tent is not met as evidenced tion, interview, and document failed to provide hearing aids ir 1 of 2 residents (R15) nunication.	1	Corrected		
	3/6/18, identified R adequate hearing,	himum Data Set (MDS) dated 15 was cognitively intact, had and wore hearing aids. ted 9/5/17, did not address				
	stated she gave he assistants at night cart. R15 continued she went four days stated she had req and was told by the	p.m. R15 was interviewed and er hearing aids to the nursing to be stored on the medication d to state that this past week, without her hearing aids. R15 uested them several times, e nurses they would bring ver did. R15 had her hearing				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
00586		00586	B. WING		04/0	05/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	•	
соок с	OMMUNITY HOSPITA	L C&NC 10 SOUT	HEAST FIFTH N 55723	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 915	Continued From pa	age 6	2 915		<u>,</u>	
		of the interview, however she e batteries were dead, and she y hearing.				
	stated R15 did not in when she started times NA-A had to NA-A stated the nu the medication cart	p.m. nursing assistant (NA)-A always have her hearing aids d her evening shift, and at request them from the nurse. rses kept the hearing aids on t, and they were responsible to hearing aids in the morning.				
	wheelchair, went to	a.m. R15 left her room via o the dining room, and sat at akfast. R15 did not have her				
	handed R15's hear training. The nurse	a.m. registered nurse (RN)-B ing aids to the nurse in in training brought the hearing ssisted her with placing them.				
	was responsible for aids, because they for safety. Further, her she went withoudays. R15's daught	a.m. NA-B stated the nurse r giving residents their hearing were on the medication cart NA-B stated R15 did report to ut her hearing aids for four ter had also brought up 5 not receiving her hearing he morning.				
	hearing aids were s Sometimes the nur them; otherwise the given when she ad RN-B stated they d residents received they were returned	a.m. RN-B stated all residents stored on the medication cart. rsing assistants asked for e hearing aids were usually ministered their medication. id not document when their hearing aids, or when to the medication cart. RN-B idents don't receive their				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	00586		B. WING		04/05/2018	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		00/2010
	OMMUNITY HOSPITA	10 SOUT	HEAST FIFTH			
		COOK, N	IN 55723			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 915	Continued From pa	age 7	2 915			
	or the hearing aids medication cart the to state many times don't receive their h	because the nurse may forget, were not returned to the e night before. RN-B continued s residents, including R15, nearing aids until noon. RN-B nould receive them when they				
	problems with resid timely. RN-D stated documentation of v aids. RN-D reviewe	a.m. RN-D stated there were dents getting their hearing aids d there should be when R15 received her hearing ed R15's medical record, s not on the care plan and				
	stated there were c receiving her hearing	p.m. family member (FM)-B ongoing issues with R15 ng aids, and when she did patteries were frequently dead.				
	On 4/5/18, at 10:40 to have hearing aid) a.m. R15 was observed not ls in.				
	given in the mornin morning medication to see if R15 had h medication cart that medication cart, an not on the cart. RN nurses responsibilit their hearing aids, the residents ears is	E stated hearing aids were of to residents, with their ns. RN-E stated he did not look er hearing aids in the the morning. RN-E checked the d stated the hearing aids were -E stated it was the medication ty to ensure the resident had the hearing aids were placed in if they wanted them, and aids were not missing.	1			
	A policy on hearing not received.	aid use was requested and				
	SUGGESTED MET	THOD OF CORRECTION:				

	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
00586		00586	B. WING		04/	05/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	I C&NC	HEAST FIFTH	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
2 915	Continued From pa	ge 8	2 915			
	develop, review, an procedures to ensu consistently provide who wear hearing a The Director of Nur educate all appropr procedures. The Director of Nur develop monitoring compliance.	ed and placed for residents				
21390	Subp. 4. Policies a control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service ed prevention and con E. a resident he immunization progr defined in part 465 procedures of resid the prevention and F. the developr employee health po	ealth program including an am, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of plicies and infection control a tuberculosis program as				5/15/18

NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING		04/05/2018	
PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
OMMUNITY HOSPITA	I C&NC		H STREET		
SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION (X5)	
		PREFIX TAG			
Continued From pa	ge 9	21390			
H. a system for products which affe disinfectants, antise incontinence product I. methods for r current standards o This MN Requirement by: Based on observati review the facility fa handwashing and g for 1 of 1 residents cares. In addition, the appropriate hand hy prevent cross conta (R11) observed for addition, the facility analyze the infection and patterns to redu-	review and evaluation of ct infection control, such as eptics, gloves, and cts; and maintaining awareness of f practice in infection control. ent is not met as evidenced on, interview, and document illed to ensure proper love usage was implemented (R4) observed for personal he facility failed to use //giene and techniques to amination for 1 of 1 resident eye drop administration. In failed to comprehensively n surveillance logs for trending uce the occurrence of the potential to affect all 26		Corrected		
Findings include:	· · · · · · · · · · · · · · · · · · ·				
personal cares, nur R4's hi-lo bed and u her wheelchair to he disposable gloves. I incontinent brief and wet, removed the bi cares. NA-D placed and put the plastic b bed. NA-D then dof pulled R4's clothing	sing assistant (NA)-D raised used a lift to transfer R4 from er bed. NA-D put on NA-D checked R4's d determined the brief was rief and provided perineal the wet brief in a plastic bag bag in the trash can near the fed gloves and immediately				
	Continued From pa G. a system for products which affe disinfectants, antise incontinence produce I. methods for r current standards o This MN Requireme by: Based on observati review the facility fa handwashing and g for 1 of 1 residents cares. In addition, th appropriate hand hy prevent cross conta (R11) observed for addition, the facility analyze the infection and patterns to redu infections. This had residents residing in Findings include: On 4/4/18, at 9:31 a personal cares, nur R4's hi-lo bed and u her wheelchair to he disposable gloves. incontinent brief and wet, removed the b cares. NA-D placed and put the plastic f bed. NA-D then dof pulled R4's clothing	PROVIDER OR SUPPLIER STREET AD OMMUNITY HOSPITAL C&NC 10 SOUTH COOK, M SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 G. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure proper handwashing and glove usage was implemented for 1 of 1 residents (R4) observed for personal cares. In addition, the facility failed to use appropriate hand hygiene and techniques to prevent cross contamination for 1 of 1 resident (R11) observed for eye drop administration. In addition, the facility failed to comprehensively analyze the infection surveillance logs for trending and patterns to reduce the occurrence of infections. This had the potential to affect all 26 residents residing in the facility. Findings include: On 4/4/18, at 9:31 a.m. during observation of personal cares, nursing assistant (NA)-D raised R4's hi-lo bed and used a lift to transfer R4 from her wheelchair to her bed. NA-D put on disposable gloves. NA-D checked R4's incontinent brief and determined the brief was wet, removed the brief and provided perineal cares. NA-D placed the wet brief in a plastic bag and put the plastic bag in the trash can near the bed. NA-D then doffed gloves and immediately pulled R4's clothing up to her waist. NA-D	PROVIDER OR SUPPLIER STREET ADDRESS, CITY, : OMMUNITY HOSPITAL CANC 10 SOUTHEAST FIFT COOK, MN 55723 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 9 21390 G. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and 21390 I. methods for maintaining awareness of current standards of practice in infection control. 1 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure proper handwashing and glove usage was implemented for 1 of 1 residents (R4) observed for personal cares. In addition, the facility failed to use appropriate hand hygiene and techniques to prevent cross contamination for 1 of 1 resident (R11) observed for eye drop administration. 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NA-D	PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE OMMUNITY HOSPITAL C&NC 10 SOUTHEAST FIFTH STREET SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREVIDERS PLAN OF CORRECT (EACH ORECTIVE ACTION SHOU CROSS-REFERENCED) Continued From page 9 21390 G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to surge proper thandwashing and glove usage was implemented for 1 of 1 residents (R4) observed for personal cares. In addition, the facility failed to use appropriate hand hygiene and techniques to prevent cross contamination for 1 of 1 resident (R11) observed for eye drop administration. In addition, the facility failed to comprehensively analyze the infection surveillance logs for trending and patterns to reduce the occurrence of infections. This had the potential to affect all 26 residents residing in the facility. Findings include: On 44/18, at 9:31 a.m. during observation of personal cares, nursing assistant (NA)-D praised R4's hi-lo bed and used a lift to transfer R4 from her wheelchair to her bed. NA-D put on disposable gloves. NA-D checked R4's incontinent brief and provided perineal cares. NA-D placed the wet brief in a plastic bag and put the plastic bag in the trash can near the bed. NA-D then doffed gloves and immediately pulled R4's clothing up to her waist. NA-D	

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		00586	B. WING		04/05/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	I C&NC	HEAST FIFTH IN 55723	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21390	Continued From pa	ge 10	21390			
	from the trash can, replaced the plastic replaced the sling of R4's bathroom and and water. Immedia completed, NA-D ch hands after she cor R4. NA-D stated th sanitize her hands of (completion of pers she did not want to NA-D stated she fo she did not carry sa stated she did not k trained to sanitize of after removing a so On 4/5/18, at 10:11 nursing (ADON) sta wash their hands at and before moving stated that she had available to staff for saw a staff membe would stop and edu ADON restated her be washed after rem moving on to other The facility Hand H 2018, directed hand before and after dir after gloving, after of hygiene for residen	the soiled incontinent brief set it on the floor, and bag with a clean one. NA-D on the chair and then went to washed her hands with soap ately after R4's cares were onfirmed she did not wash her mpleted incontinence cares for hat she usually did not wash or until the end of the process ional cares) with R4 because leave R4 with her bed raised. rgot to wash her hands, and anitizer in her pocket. NA-D know whether she had been or wash her hands immediately iled incontinent brief. a.m. the assistant director of ated she expected staff to fter removing soiled gloves, on to other tasks. The ADON pocket sized hand sanitizers r use. The ADON stated if she r fail to wash their hands, she ucate staff in the moment. The rexpectation that hands are to moving soiled gloves, before tasks. ygiene policy dated January d hygiene was to be performed ect contact with a resident, engaging in acts of personal ts, and other situations.				
		Artificial Tears eye drops,				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00586	B. WING		04/05/2018	
AME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE	1 • •	
оок с	OMMUNITY HOSPITA		HEAST FIFTH	STREET		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	IN 55723	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	COMPLE DATE
21390	Continued From pa	ige 11	21390			
	medication pass. R medications and ey RN-B did not wash administration. RN- medication first. RN open, touching the ungloved left hand, artificial tears into the tip of eye drop bottl repeated the pract touching the tip of the eyelid. RN-B return manipulated items cart drawer. When during eye drop add wore gloves, "Some eye drops in the medidocumented on the washing or sanitizin administration of ey resident's eyes, RN sanitizes her hands documenting on the should have sanitiz eye drop administration (DON) verified nurs glove prior to admini instill eye drops with bottle to the eye lid should remove glow hands immediately drops. The facility policy H directed hand hygin	ve drops at the medication cart hands prior to medication B administered R11's oral J-B then held R11's right eye outside of his eyelid with her and administered a drop of he right eye while touching the e to R11's eyelid. RN-B ice on R11's left eye, again he eye drop bottle to R11's ed to the medication cart, on the cart, and opened the asked about wearing gloves ministration, RN-B stated she etimes." RN-B put away the edication cart, and e computer. When asked about ng hands following /e drops and touching a I-B stated she washes or after she is done e computer. RN-B stated she red her hands right away, after ation. a.m. the director of nursing ses should wash hands and histration of eye drops, then hout touching the eye drop . The DON stated nurses /es and sanitize or wash after administration of eye				

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(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T DEFICIENC		DATE
21390	Continued From pa	ge 12	21390			
	prior to passing out resident medication	medication, and in between administration.				
	included three urina results were not inc infection, and one of lacked a written and include if the urinar	7, infection surveillance log ary tract infections (culture cluded on the log), one scalp case of pneumonia. The facility alysis of the infections to y tract infections were related, vere implemented to reduce ons.				
	included four urinar organisms causing E. coli and one E. fa written analysis of t urinary tract infectio	infection surveillance log y tract infections. The the infections included three aecium. The facility lacked a he infections to include if the ons were related, or if implemented to reduce urinary				
	included one urinar coli, one skin infect	, infection surveillance log y tract infection caused by E. ion and one case of cility lacked a written analysis				
	(the facility infection January of 2018 the logged infections. F all organisms for cu reported only the nu the infection control and currently did no infections in the fac analysis was to lool	b.m. registered nurse (RN)-C in preventionist), stated in e facility changed how they from January on, they included ultures. RN-C stated she umber and type of infections to I meeting every three months, of do a written analysis of the cility. The purpose for a written k for trends and patterns of by were noted, education or by more noted, education or				

	IT OF DEFICIENCIES OF CORRECTION	CAITH (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00586	B. WING		04/	05/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	AL C&NC 10 SOUT	HEAST FIFTH	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From pa	age 13	21390			
	for Hospital Care C trends or concerns necessary care cer The policy did not i analysis monthly to SUGGESTED MET The Director of Nur preventionist or des and/or revise polici an infection control and surveillance of physician's orders to The Director of Nur designee could dev policies and procec hygiene practices of cares, and adminis The Director of Nur preventionist or des appropriate staff or The Director of Nur preventionist or des monitoring systems compliance.	signee could develop, review, es and procedures to ensure program includes tracking antibiotic use when a for antibiotics is received. rsing, infection preventionist, or velop, review, and/or revise dures to ensure proper hand during and following personal tration of eye drops. rsing and infection signee could educate all in the policies and procedures.				
21435	(21) days. MN Rule 4658.090 Recreation Program	0 Subp. 1 Activity and n; General	21435			5/15/18
	home must provide recreation program based on each indi strengths, and nee	al requirements. A nursing an organized activity and . The program must be vidual resident's interests, ds, and must be designed to mental, and psychological				

If continuation sheet 14 of 35

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00586	B. WING		04/	05/2018
IAME OF F	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
соок с		AL C&NC	HEAST FIFT IN 55723	H STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21435	Continued From pa	age 14	21435			
	comprehensive res comprehensive pla 4658.0400 and 46 provided opportunit	resident, as determined by the sident assessment and in of care required in parts 58.0405. Residents must be ties to participate in the opment of the activity and i.				
	by: Based on observat review, the facility f activities were prov	ent is not met as evidenced ion, interview, and document failed to ensure meaningful vided to 3 of 4 residents (R1, d for dementia care.		Corrected		
	Findings include:					
	indicated R1's diag dementia, agitation	hysical dated 1/31/18, noses included severe n, mood instability, and chronic extensive to full assist with ring.				
	2/5/18, indicated R others and was sor had severely impai decision-making, h rejection of cares. I had physical, verba	mum Data Set (MDS) dated 1 sometimes understood metimes understood by others, red cognitive skills for ad delusions and had no R1's MDS further indicated R1 al and wandering behaviors 1 e assessment period.				
	somewhat importar	dated 11/9/17, indicated it was nt to R1 to listen to music, be things with groups of people,				
		sessments (CAA) dated tive loss/dementia indicated				

TATEMENT OF ND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00586	B. WING		04/05/2018	
AME OF PRO	IDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE. ZIP CODE	•	
		10 SOUT	HEAST FIFTH			
OOK COM	MUNITY HOSPITA	COOK, N	IN 55723			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPI THE APPROPRIATE DAT	
21435 Co	ntinued From pa	ge 15	21435			
cel im de ha dis ind im an CA ac wa tim wit R1 at me an rer mii wit roo a c inc 1:1 wa ac inc ta foll	nter, had a mode bairment, and wa cisions. R1's cog d difficulty focusin tracted. R1's CA icated R1 did no bortance of partic d had variable m A indicated R1 w civities for approx tch game shows e wandering in h h staff, watching 's care plan date risk for impaired emory loss, short d easily agitated. nain at three gro nutes, would use h other residents bom and socialize loll and visit with luded allow R1 d visits, coffee gro rm, verbal remin ivities of choice, lways, hold stuffe da, and visit or si icated R1 require ff to sit with her a ve an activity cale all music prograr all games. 's activity docum owing:	wheelchair around the care erately impaired cognitive as able to make simple daily initive loss CAA indicated R1 ng attention, and was easily A for psychosocial well-being t answer questions regarding cipation in favorite activities, oods during activities. R1's would stay and observe cimately 45 minutes, or would on the television. R1 spent hallways, holding a doll, visiting tv and attending activities. ed 12/23/14, indicated R1 was social interaction due to attention span, wandering, R1's goals included R1 would up activities weekly for 30 e leisure time independently, si a and watch tv in the activity at least twice weekly, and hold staff. R1's interventions lecision making for activities, oups, take outside when ders of activity times, attend self propel wheelchair in the ed animal or baby, have a it with staff. R1's care plan ed assistance to activities and at group activities. R1 was to endar in her room, be brought ms, observe active games, and entation indicated the at 180 minutes in an	t d			
	dentified activity. ment of Health					

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00586	B. WING		04/	05/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	L C&NC	HEAST FIFTH IN 55723	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH		PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21435	Continued From pa	ge 16	21435			
	in a 1:1 visit, coffee -on 4/2/18, in the af minutes in a 1:1 visit others. -on 4/2/18, in the minite exercise, tv, walk staff -on 4/1/18, in the af in a 1:1 visit, coffee -on 3/31/18, in the af minutes in a 1:1 visit others -on 3/30/18, in the af minutes reading/wr and a 1:1 visit -on 3/30/18, in the final state watching tv/movies doll and sitting with		3			
	in these activities o minutes to 360 min Documentation for indicated R1 partici observing others fo	the afternoon on 4/3/18, pated in coffee group and r 180 minutes, and on the R1 participated in pet visits,				
	wandering in the har The outside door al removed from the a observed in the day	o.m. R1 was observed allway and into others' rooms. larm sounded and she was area. At 6:25 p.m. R1 was y area on the unit, smiling and lers. Staff took her to her room				
	was observed to ea	n 8:48 a.m. and 10:18 a.m. R1 at breakfast, wander in the t, sit and look out the windows				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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соок с	OMMUNITY HOSPITA	L C&NC	THEAST FIFTH AN 55723	STREET		
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21435	Continued From pa	ge 17	21435			
		, then hold a doll and talk to on the other unit at that time, e cream.				
		ວິ a.m. nursing assistant vandered, but has wandered o the new unit.				
	wandering in the har occasionally staff s continued on their v In the common acti	b.m. R1 was observed allways on the unit, and topped to say hello, and way. R1 was holding the doll. vity area, other residents were pets were observed visiting day.				
	On 4/5/18, at 9:37 a the counter after ea	a.m. R1 was sitting quietly at ating her breakfast.				
	R1 has not had a b unit. H-A stated R1 rooms. H-A stated I three. H-A also stat liked her nails done every so often, or th	a.m. housekeeper (H)-A stated ad day since moving the new wandered less into others' R1 liked her dolls and had ed R1 liked her stuffed cat, e so activities will do her nails ney would do 1:1 visits with usually does not go to group she wanders.	3			
	stuffed cat and R1	a.m. H-A brought R1 her talked to the cat, which was ne morning on the unit, holding about the unit.	3			
	indicated R17's dia advanced Alzheime R17's History and F R17's dementia, an	Physical dated 12/19/17, gnoses included a stroke, er's dementia, and depression. Physical further addressed Id directed nursing to continue to stimulate her, and				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	AL C&NC	HEAST FIFTH IN 55723	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21435	Continued From pa	age 18	21435			
		articipate as able, and noted watching the Price is Right s.				
	R17 had severely in daily decision makin hallucinations, and 1-3 days during the MDS further indicate assistance of staff and locomotion off comprehensive ME survey, indicated R important for R17 to was good, otherwise	OS dated 12/21/17, indicated mpaired cognitive skills for ing, had symptoms of delirium, physical and verbal behaviors e assessment period. R17's ted R17 required total with locomotion on the unit, the unit did not occur. R17's OS, in process during the t17 indicated it was very o go outside when the weather se, activities listed were either or not important at all to R17.				
	impaired cognitive abilities, had sympt disorganized thinkin psychosocial well-b CAA which indicate	cated R17 had severely skills for daily decision making toms of inattention and had ng. R17's CAA for being referred to the mood ed R17 had no signs or ession. R17's CAAs did not				
	following: -on 4/5/18, in the m exercise, visitors, a -on 4/4/18, in the e TV/movies and 1:1 -on 4/4/18, in the m tv/movies for 45 mi -on 4/3/18, in the la	ater afternoon, R17 participated sits, coffee group, and the				

STATE FORM

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00586	B. WING		04/	05/2018
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE	•	
COOK C	OMMUNITY HOSPITA	I C&NC		STREET		
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21435	Continued From pa	ige 19	21435			
	birds, observing oth 180 minutes. -on 4/2/18, in the ev tv/movies, 1:1 visits others for 120 minu- -on 4/2/18, in the m visits and coffee gr -on 4/1/18, in the af tv/movies, 1:1 visits (sleeping) for 360 m Further activity doc participated in thes for 30 to 360 minute sleeping time, sittin observing others, w A review of R17's a activity calendar for was not taken to gr BINGO on 3/17 and February 2018.	orning R17 participated in pet oup for 45 minutes. fternoon R17 participated in s, observing others and "zzzzz" ninutes. umentation indicated R17 e activities 1 to 2 times daily, es. Several entries included g in front of the TV, and vithout interaction as activities. Inclivity participation and the r March 2018, indicated R17 oup activities, including d 3/31. The same was true in				
		a.m. R17 was sitting quietly in d was assisted by staff to eat				
		a.m. R17 was moved from the of the TV in the day area.				
	room, and at 10:01	a.m. R17 was brought to her a.m. she was brought down to o sit in the sunlight.				
		o.m. R17 was lying quietly in activity in the day area with seeds.				
		a.m. R17 was sitting in front of with her eyes closed, following				

	ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COM	PLETED
		00586	B. WING		04/05/2018	
	OVIDER OR SUPPLIER		I DRESS, CITY, ST	TATE, ZIP CODE		00/2010
	MMUNITY HOSPITA	L C&NC 10 SOUTH	IEAST FIFTH			
		COOK, M	N 55723			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21435 (Continued From pa	ige 20	21435			
t f f () () () () () () () () () () () () ()	o go out to sit in fro riends, and R17 sa R17 to her room for On 4/5/18, at 9:51 a unit day area and p closed eyes. R17 s residents or staff in director (AD)-A retu unit without taking F On 4/4/18, at 9:58 a displayed physical F cares, but R17's be moving to the new f R17 in the sun for 2 activities staff tend residents who are u activities, to group a	a.m. R17 was returned to the laced in front of the TV, with at there alone, without other the area. At 9:54 a.m. activity urned to the unit and left the				
() () () () () () () () () () () () () (On 4/5/18, at 11:28 (DON) stated deme and verified there w on 4/4/18, as docur documentation. The residents with demo front of the birds an were not engaging were trying to revar engaging R1 in acti wandering into othe do more baking and evenings, and the r are very good with On 4/5/18, at 11:44	a.m. activity director (AD)-A				
	stated if residents v	vere unable to participate in				

00586 Street ad	B. WING			
			04/05/2018	
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EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG		I SHOULD BE	(X5) COMPLET DATE
ge 21 ake them to the group, the do their nails, etc. AD-A e group activities is beneficial d not done 1:1 activities with ons. AD-A stated R1 usually nd families sit with her. AD-A uded everything, including the rified pets did not visit as stated they make sure ntia are seen by activities staff participate in dementia eduled to attend the training. hold a doll or her cat, and taff when they are charting. s brought to a quiet place, in the sun because she did stated they do not bring R17 os or music programs, as r. AD-A stated they do nails or R1 and R17. AD-A stated scheduled for them. ble to provide a policy on ts with dementia. ated 3/19/18, indicated R16's altered mental status, major and unspecified psychosis. hysical dated 1/26/18, ed much of therapy, most of d medication; resident is on	21435	DEFICIENCY)		
	MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) e 21 ake them to the group, the do their nails, etc. AD-A e group activities is beneficial not done 1:1 activities with ns. AD-A stated R1 usually d families sit with her. AD-A ded everything, including the ified pets did not visit as tated they make sure ntia are seen by activities staff participate in dementia eduled to attend the training. nold a doll or her cat, and aff when they are charting. s brought to a quiet place, the sun because she did tated they do not bring R17 os or music programs, as . AD-A stated they do nails or R1 and R17. AD-A stated scheduled for them. ble to provide a policy on s with dementia. tet 3/19/18, indicated R16's altered mental status, major and unspecified psychosis. hysical dated 1/26/18, ed much of therapy, most of d medication; resident is on	MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) PREFIX TAG e 21 21435 ake them to the group, the do their nails, etc. AD-A e group activities is beneficial not done 1:1 activities with ns. AD-A stated R1 usually df families sit with her. AD-A ded everything, including the ified pets did not visit as tated they make sure thia are seen by activities staff participate in dementia eduled to attend the training. hold a doll or her cat, and aff when they are charting. s brought to a quiet place, the sun because she did tated they do not bring R17 bs or music programs, as . AD-A stated they do nails ir R1 and R17. AD-A stated scheduled for them. ble to provide a policy on s with dementia. attered mental status, major and unspecified psychosis. mysical dated 1/26/18, ed much of therapy, most of d medication; resident is on ewed 2/27/18, indicated R16 red psychosocial wellbeing that staff wanted to harm ns included R16's preference	AUST BE PRECEDED BY FULL PREFIX TAG (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY) e 21 21435 ake them to the group, the botheir nails, etc. AD-A e group activities is beneficial i not done 1:1 activities with ns. AD-A stated R1 usually df amilies sit with her. AD-A ded everything, including the ified pets did not visit as tated they make sure thia are seen by activities staff participate in dementia eduled to attend the training. nold a doll or her cat, and aff when they are charting. s brought to a quiet place, the sun because she did tated they do not bring R17 ss or music programs, as . AD-A stated they do nails r R1 and R17. AD-A stated scheduled for them. wle to provide a policy on s with dementia. wlet 3/19/18, indicated R16's altered mental status, major and unspecified psychosis. nysical dated 1/26/18, ed much of therapy, most of d medication; resident is on ewed 2/27/18, indicated R16 ed psychosocial wellbeing that staff wanted to harm ns included R16's preference	AUST BE PRECEDED BY FULL PRÉFIX TAG CROSHEREFERNCED TO THE APPROPRIATE DEFICIENCY) e 21 21435 ake them to the group, the do their nails, etc. AD-A group activities is beneficial not done 1:1 activities with ns. AD-A stated R1 usually difamilies sit with her. AD-A ded everything, including the iffed pets did not visit as tated they make sure thia are seen by activities staff participate in dementia aduled to attend the training. iold a doll or her cat, and aff when they are charting. s brought to a quiet place, the sun because she did tated they do not bring R17 ps or music programs, as . AD-A stated they do nails r R1 and R17. AD-A stated scheduled for them. be to provide a policy on s with dementia. weed 2/27/18, indicated R16's altered mental status, major and unspecified psychosis. nysical dated 1/26/18, do much of therapy, most of d medication; resident is on

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(X4) ID PREFIX TAG	((EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S		ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21435	Continued From pa	age 22	21435			
	indicated a risk for R16 wanted to rem the day, or in a rec often yelled out wh Interventions includ and spouse at mea preferred to sit thro while she's sitting i reminders of activit activities using whe encouragement to active games. R16 will observe the pic	omfort. The care plan also impaired social interaction as hain in a certain place most of liner. The care plan noted R16 en seen on a 1:1 basis. ded providing a picture of R16 al table as this was where she bughout the day, offer coffee n the dining area, verbal ty times, bringing resident to eelchair, table games, attend music programs, and S's goal was specified that she sture of spouse and self, three h, and resident will accept 1:1 yeekly.				
	month of February consistently include general activities. days included com as TV or movies, 1 observing others, a varying from 20 mi activities recorded included 1:1 visit re recorded 53 times day), observing oth as an activity 38 tim times, observing R (though picture obs each meals observ x-ray recorded as a recorded once, par recorded once, pet recorded once, beat talked about dancin	mentation records for the 5, 2018, through April 4, 2018, ed combined recording of very Daily recordings for those 59 bined activities participated in :1 visit, coffee group, and sleeping for lengths of time nutes to 360 minutes. All 2/5/18, through 4/4/18, ecorded 61 times, coffee group (often more than once per hers and/or sleeping recorded nes, TV or movies recorded 49 16's picture recorded twice served to be in front of R16 for red during survey), took R16 to an activity once, luncheon ty recorded once, children : visits recorded once, visitors auty shop recorded once, ng recorded once, read R16's corded once, and music activity				

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NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE	•	
соок с	OMMUNITY HOSPITA	AL C&NC	HEAST FIFTH	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21435	Continued From pa	age 23	21435			
	R16 at 1:08 p.m. in in today - TV or Mo Activities Not Listed Time in Activity - 18 documentation reco p.m. listed Activities Movies and Sleepir noted that 180 minu activity staff record On 4/4/18, at 2:02 p was interviewed. W experienced chang stated R16 used to never participated. herself, and doesn' the other residents On 4/4/18, at 2:04 p started working with slept more during the rough night. On 4/4/18, at 2:04 p she visits with R16 response currently used to dance with she was in a wheel joked with R16 and that anymore. NA- now as part of the o	p.m. nursing assistant (NA)-E /hen asked if R16 had les in activity levels, NA-E sit and watch activities but NA-E stated now R16 sits by t usually eat at the same time eat. p.m. NA-D stated she recently h R16, and had noted that R16 he day, especially if she had a p.m. NA-C stated that when she didn't get as much as she did previously. NA-C R16 by taking her hands while chair. NA-C stated she had I had fun, but R16 doesn't do C noted that R16 slept more decline of aging. ed Alzheimer's Disease and naterials provided did not on meaningful activities for	r			

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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	L C&NC 10 SOUT	HEAST FIFTH N 55723	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
21435	Continued From pa	ge 24	21435			
	The Director of Nur designee could dev policies and proced activities for resider provided. The Director of Nur designee could edu the policies and pro The Director of Nur designee could dev ensure ongoing cor	sing and activity director or elop monitoring systems to				
21530	A. The drug regim reviewed at least m currently licensed b This review must be Appendix N of the S Surveyor Procedure Requirements in Lo the Department of H Health Care Financ This standard is ind available through th system. It is not su B. The pharma irregularities to the and the attending p must be acted upor physician visit, or so pharmacist. For pu upon" means the attending	A.B.C Drug Regimen Review en of each resident must be onthly by a pharmacist y the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service ing-Term Care, published by Health and Human Services, ing Administration, April 1992. corporated by reference. It is the Minitex interlibrary loan bject to frequent change. cist must report any director of nursing services hysician, and these reports to by the time of the next boner, if indicated by the rposes of this part, "acted cceptance or rejection of the ng or initialing by the director	21530			4/30/18

Iinnesota Department of Hea TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	LE CONSTRUCTION		E SURVEY PLETED
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AME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	•	
OOK COMMUNITY HOSPITAL	C&NC	HEAST FIFT	H STREET		
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21530 Continued From page	ge 25	21530			
C. If the attendid with the pharmacist not provide adequat pharmacist believes being adversely affe refer the matter to th if the medical director physician. If the me the attending physic justification for the o physician does not o must be referred for assessment and ass by part 4658.0070. the medical director	and the attending physician. ng physician does not concur 's recommendation, or does the justification, and the the resident's quality of life is acted, the pharmacist must the medical director for review or is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter review to the quality surance committee required If the attending physician is r, the consulting pharmacist er directly to the quality surance committee.				
by: Based on interview a facility failed to ensu- recommendations w of nursing (DON) an of 5 residents (R9, F addition, the facility f recommendations w	ent is not met as evidenced and document review, the ure pharmacy vere reviewed by the director nd medical director (MD) for 5 R27, R6, R3, and R16). In failed to ensure pharmacist vere responded to timely for 1 reviewed for unnecessary		Corrected		
included acute kidne	licated R9's diagnoses ey failure, dementia, l atherosclerotic heart				

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NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		0012010
	OMMUNITY HOSPITA	L C&NC	HEAST FIFTH	STREET		
		COOK, N	/IN 55723			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21530	Continued From pa	ige 26	21530			
	1/17/18, indicated F mood symptoms, h depression and pai R9 received antips antidepressant, and medications during R9's Physician Ord medications that im- pain medications in medications, anticor medications, antior antidepressant medi medications, and s R9's monthly consu- included several re review and follow u pharmacy consultar reviewed and follow but lacked review b director. R27's Face Sheet i included acute kidm wheezing, and term R27's annual MDS	R9 was cognitively intact, had allucinations, anxiety, n. R9's MDS further indicated sychotic, antianxiety, icoagulant, diuretic, and opioid the assessment period. ers included orders for cluded dementia medications, icluding opioids, antipsychotic bagulant medications, diuretic d medications, blood pressure inxiety medications, dications, respiratory leep aid medications. ultant pharmacist reviews commentations requiring p by the physician. R9's int recommendations were wed up on by R9's physician, by the DON and the medical indicated R27's diagnoses inter failure, anemia, pain, ninal atrophy of the kidney. dated 1/14/18, indicated R27	ŀ			
	depression, depres daily activities, and and diuretic medica					
	antidepressant med blood pressure med medications.	ders for medications included dications, pain medications, dications, and diuretic				
	R27's monthly conservent of Health	sultant pharmacist reviews				

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00586	B. WING		04/	05/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	·	
соок с	OMMUNITY HOSPITA	AL C&NC	THEAST FIFTH MN 55723	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 27	21530			
	review and follow u pharmacy consulta reviewed and follow but lacked review b director. R6's quarterly MDS diagnoses of high b cholesterol, and de included antipsycho antidepressant med medications.	dications, and diuretic				
	included recomment follow up by the phy consultant recommend followed up on by F	ultant pharmacist reviews ndations requiring review and ysician. R6's pharmacy nendations were reviewed and R6's physician; however, the DON and the MD.				
		8 dated 1/6/18, identified blood pressure and high				
	identified orders for including Norvasc,	ler Sheet dated 3/27/18, r blood pressure medications Apresoline, Zestril, Lopressor er Sheet identified an order for lesterol.				
	R3's pharmacy me following recomme	dication reviews identified the ndations:				
		sulting pharmacist physician to clarify the blood pressure checks.				
	- 12/7/17, the construction recommended che	ulting pharmacist cking R3's fasting lipid panel				

STATE FORM

310F11

If continuation sheet 28 of 35

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00586	B. WING	04		05/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
соок с		AL C&NC	THEAST FIFTH AN 55723	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21530	Continued From pa	age 28	21530			
		sterol levels) to ensure y. The last fasting lipid panel tober of 2016.				
	the 12/7/17, consul recommendations	not address the 11/24/17, and Iting pharmacist in writing, nor were the reviewed by the DON or MD.				
	stated it had been lipid panel complet address ordering th not ordering it. In a address how often checked. R3 did no frequency of blood them weekly and a for pharmacy const the pharmacist con in the medical reco given to her self or physicians rounding	p.m. registered nurse (RN)-D a year and half since R3 had a ed. The physician failed to ne lipid panel or justification for ddition, the physician failed to R3's blood pressure should be of have a specific order for pressure checks and received s needed. The current process ult recommendations included npleting the recommendations ord. They were then printed and a designee to place in the g forms to address. There was to ensure the physician ecommendations.				
	he did not review the recommendations them either. The D to get the physician recommendations.	rector of nursing (DON) stated ne pharmacy consults and the MD did not review ON stated it was a challenge ns to address all the identified There was not a current the physician addressed the				
	stated she sends th recommendations needed an immedia	nsulting pharmacist (CP) he irregularities and to the DON and MD. If she ate response from a physician e physician herself. The CP	,			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00586	B. WING		04/	05/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	L C&NC 10 SOUT COOK, M	HEAST FIFTH	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21530	Continued From pa	ge 29	21530			
		gets a timely response on her and the physician's approve				
	dated 2017, directed discovered an irreg in the residents mean forwarded to the phairregularities and re- added to a spread so would be used for for recommendations we for completion and the physician. A rep- end of the month. To irregularities and re-	are Center Medication Review d when the pharmacist ularity it would be documented dical record and printed and ysician for review. All commendations would be sheet in the pharmacy, which ollow up. The would be reviewed quarterly if appropriate re-submitted to port would be generated at the The report would include all commendations and would be of nursing and medical staff				
	diagnoses that inclued edema, essential hy (blood potassium le	lated 3/19/18, identified uded altered mental status, ypertension, hypokalemia evels are too low), major r, and unspecified psychosis.				
	9/15/17, included: Recommend check	narmacist monthly review note Medication review for August: ing potassium level because or edema. Last level was in				
	dated 10/16/17, inc September: Mirtaza reduction or docum appropriate. Recor	narmacist monthly review luded: Medication review for apine due for a gradual dose entation why it is not nmend rechecking potassium suse; last level is from				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00586	B. WING		04/05/20	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
OOK C	OMMUNITY HOSPITA		HEAST FIFTH	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21530	Continued From pa	age 30	21530			
	11/10/17, included: October: Recomm level as furosemide level is from Februa R16's MD notes da	harmacist monthly review note Medication review for lend rechecking a potassium e is expected to lower it. Last ary 2017. Inted 10/31/17, 11/09/17, and n order to check for a				
	pharmacist puts in recommendation g nursing. During the the physician sees would expect the M stated that the facil DON and other nur pharmacist recom action the physician recommendations. doing the monthly r consultant pharma a week or even at t DON stated they do make sure the physician	p.m. the DON stated when the a recommendation, the ets printed out, and goes to a monthly resident MD rounds, the recommendation, and he ID act upon it. The DON ity lacked a process for the rses to see the consultant mendations, and see any n took on the The DON stated the MD rounding should respond to the cist's recommendations within the next monthly review. The o not have a system in place to sician responds to the cist's recommendations.				
	The Director of Nur develop, review, ar procedures to ensu- recommendations nursing and medica recommendations resident's physician The Director of Nur	THOD OF CORRECTION: rsing or designee could ind/or revise policies and ure pharmacist are reviewed by the director of al director review pharmacist and responded to the in a timely manner. rsing or designee could riate staff and medical director				

STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY IPLETED
		00586	B. WING		04/	05/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	L C&NC 10 SOUT COOK, M	HEAST FIFTH IN 55723	STREET		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COI		(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLET DATE
21530	Continued From pa	ge 31	21530			
		sing or designee could systems to ensure ongoing				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21545	MN Rule 4658.1320	A.B.C Medication Errors	21545			5/15/18
	percent as described Guidelines for Code 42, section 483.25 of the State Operation Surveyors for Long- incorporated by refe purposes of this par (1) a discrepar prescribed and wha administered to res (2) the adminis medications. B. It is free of a error. A significant (1) an error v discomfort or jeopa safety; or (2) medication requires the medication be titrated to a spec medication error co precipitate a reoccu toxicity. All medication prescribed. An inc error report must be that occurs. Any sig- resident reactions medications medications for that occurs.	on error rate is less than five ed in the Interpretive e of Federal Regulations, title (m), found in Appendix P of is Manual, Guidance to -Term Care Facilities, which is erence in part 4658.1315. For rt, a medication error means: ncy between what was at medications are actually idents in the nursing home; or stration of expired				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00586	B. WING		04/05/2018	
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY,	RESS, CITY, STATE, ZIP CODE		
	OMMUNITY HOSPITA	10 SOUT	HEAST FIFT			
		COOK, I	MN 55723			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21545	Continued From pa	age 32	21545			
	designated represe must be made in th C. All medicati prescribed. An inci report must be filed occurs. Any signifi resident reactions r physician or the ph resident or the resid designated represe	dent's legal guardian or entative and an explanation ne resident's clinical record. ons are administered as ident report or medication error d for any medication error that cant medication errors or must be reported to the ysician's designee and the dent's legal guardian or entative and an explanation ne resident's clinical record.	r			
	by: Based on observat review, the facility f were not crushed w of 9 residents (R11 medication adminis medication error ra	ent is not met as evidenced ion, interview, and document failed to ensure medications vithout a physician's order for 2 , R19) observed for stration. This resulted in a te of 14%.	2	Corrected		
	indicated R11's dia	Physical dated 7/10/17, gnoses included chronic pain, ion and esophageal strictures.				
	included orders for to support eye heal twice daily, Ultram milligrams (mg) po (nonsteroidal anti-in	cian Orders dated 2/23/18, : Occuvite with Lutein (vitamin Ith) one tab po (by mouth) (pain medication) 50 three times daily, Aleve nflammatory) 220 mg po twice lack directives to crush				
	On 4/2/18, at 5:37 epartment of Health	p.m. during observation of				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00586	B. WING		04/05/2018	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		04/	05/2010
		10 SOUT	HEAST FIFTH			
COOK C	OMMUNITY HOSPITA	AL C&NC	/IN 55723			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21545	Continued From pa	age 33	21545			
	crushed R11's napi Occuvite, and tram prior to administrati administered the cr applesauce to R11 medications crushe an order for crushin the medications we knew.	egistered nurse (RN)-A roxen sodium (Aleve), adol (Ultram) medications ion of these medications. RN-A rushed medication in . RN-A stated R11 has ed, but did not know if R11 had ng medications. RN-A stated ere okay to crush as far as she p.m. RN-A verified R11 did not ush medications.				
	On 4/3/18, at 11:43 medication pass, R part, they give R11 ¹ stated R11 does be sometimes they cru depending on his s this morning they c gave them in 3 spo	p.m. during observation of N-B stated that for the most 's medications whole. RN-B etter as the day goes on, but ush his medications, wallowing ability. RN-B stated rushed R11's medications and onfuls. RN-B proceeded to madol whole in applesauce,				
	indicated R19's dia	Physical dated 6/28/17, gnoses included Alzheimer's one loss) with a history of				
	included orders for mg po four times d	ician Orders dated 3/28/18, Tylenol (acetaminophen) 650 aily for arthritis. R19's cked orders to crush				
	acetaminophen, an	a.m. RN-B crushed R19's ad administered it in . RN-B incorrectly stated R19 ish medications.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00586	B. WING		04/05/2018	
AME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE			
OOK C		10 SOUT	HEAST FIFTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21545	Continued From pa	age 34	21545			
	(DON) verified med crushed without a p The facility policy A Long Term Care da to crush pills when) a.m. director of nursing dications were not to be physician's orders. Administration of Medication in ated 4/13/17, directed nursing necessary according to nanufacturer's information,				
	pharmacist, and dr procedure further i crushed together u	ug reference. The policy and ndicated medications may be inless contraindicated by anufacturers information or				
	The Director of Nu develop, review, ar procedures to ensu crushed and mixed order by the physic The Director of Nu educate all approp procedures. The Director of Nu	THOD OF CORRECTION: rsing or designee could nd/or revise policies and ure medications are not d together without a review and cian. rsing or designee could riate staff on the policies and rsing or designee could g systems to ensure ongoing				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				