DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 31OF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00586

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245392**

2.STATE VENDOR OR MEDICAID NO.
(L2) **752547802**

3. NAME AND ADDRESS OF FACILITY
(L3) **COOK COMMUNITY HOSPITAL C&NC**
(L4) **10 SOUTHEAST FIFTH STREET**
(L5) **COOK, MN** (L6) **55723**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/29/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **28** (L18)
13.Total Certified Beds **28** (L17)

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 Following Requirements:
___ 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
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	28			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date:
Terri Ament, Unit Supervisor 06/08/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas S. Larson, Enforcement Specialist 06/08/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/08/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health

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,

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 31OF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00586

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(L1) **245392**
2.STATE VENDOR OR MEDICAID NO.
(L2) **752547802**

3. NAME AND ADDRESS OF FACILITY
(L3) **COOK COMMUNITY HOSPITAL C&NC**
(L4) **10 SOUTHEAST FIFTH STREET**
(L5) **COOK, MN** (L6) **55723**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/05/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

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13.Total Certified Beds **28** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 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
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	28			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE - NE II 05/02/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 05/04/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

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: 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:

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

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

Remedies - 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;

Potential Consequences - 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

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING _____ B. WING _____	04/05/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 4/2/18, through 4/5/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On April 2, 2018, through April 5, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 563 SS=F	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident.	F 563		5/15/18

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

Electronically Signed | 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING _____ B. WING _____	04/05/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 563	Continued From page 1 (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to allow residents visitation rights during an influenza outbreak. This had the potential to affect all 26 residents residing in the facility. Findings include: The Influenza-Like Illness Line List from 2/25/18, through 3/1/18, identified 11 residents with influenza-like symptoms. Three of the 11 residents had a confirmed Influenza A diagnosis. The first confirmed case of Influenza A was on 2/26/18. The Line List identified all 11 residents	F 563	The Cook Hospital and Care Center has reviewed the policy and procedure specific to resident rights to receive visitors of his or her choosing. The policy was found to be in compliance with resident rights but was not followed. Upon family complaint the restriction of visitors was lifted. Staff education on policy and procedure for resident□s rights to visitors was conducted beginning 04/07/18 including Long Term Care staff and Infection Preventionist. This education will be complete May 15, 2018. To ensure compliance of regulation on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING _____ B. WING _____	04/05/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 563	Continued From page 2 were placed on precautions, with the last day of a resident on precautions being 3/8/18. The facility closed their doors to visitors from 2/26/18, through 3/12/18. On 4/2/18, at 6:27 p.m. R25 was interviewed, and stated she had to stay in her room for five days because of influenza. Further, R25 stated the facility would not allow any visitors, and then family members had complained. R25 stated the facility did not discuss with the residents about denying visitors, but told the residents they were not going to allow visitors. On 4/3/18, at 11:13 a.m. family member (FM)-A stated the facility called and notified her they were not allowing any visitors, because there was an influenza outbreak in the facility. FM-A stated she was not sure how long the restrictions lasted, but the facility had called and let her know when she could visit the facility again. At 1:28 p.m. during the resident council meeting R2, R9, R14, R25, and R27, all stated the facility administration shut down the facility to all visitors including family during an influenza outbreak. R25 added it was lonesome without visitors. On 4/4/18, at 10:09 a.m. registered nurse (RN)-D stated the facility policy directed to restrict visitors when there was an influenza outbreak; and it had been done in the past. Further, the families and residents were notified of the restrictions on visitation; however a few families became upset, and then the restrictions were removed. RN-D stated the restriction on visitors was not well received by the families, and the facility was trying to protect the residents.	F 563	resident right to visitors it will become part of facility annual education. Education includes responsibility of facility to allow immediate access to residents by A.Any representative of the Secretary of the Department of Health and Human Services B.Any representative of the State C.The resident□s individual physician D.The State long term care ombudsman E.The agency responsible for the protection and advocacy system for developmentally disabled individuals F.The agency responsible for the protection and advocacy system for the mentally ill G.The Resident Representative, other named family or acquaintances H. It is the facilities responsibility to only suggest visitors that are feeling ill to restrict their visitation but provide gloves and mask and / or gown to those wishing to visit a resident. To ensure our resident rights are being properly managed, the Cook Care Center director of nursing or designee will interview 2 residents per week for 6 weeks. The DON or designee will ask the resident if they feel that any of their rights to have visitors have been denied by our facility. This audit interview will be documented and updated at IDT twice weekly and brought to QAPI committee. Director of Nursing is responsible for the overall compliance of this regulation.	

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F 563	Continued From page 3 At 10:33 a.m. the director of nursing (DON) stated he did not even question the closing of the facility to visitors. He stated the facility infection preventionist put the restrictions in place. After families complained, the restrictions were lifted. On 4/5/18, at 1:32 p.m. RN-C (the facility infection preventionist), stated she did some research, and thought it would be appropriate to restrict visitation to the facility during the facility's influenza outbreak. RN-C stated she did not take into account the resident's rights to have visitors. The facility policy Visitation in Long Term Care dated 1/10/17, identified the resident had the right, and the care center must provide immediate access per their wishes to family and non-family visitors.	F 563		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living.	F 676		5/15/18

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F 676	Continued From page 4 The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide hearing aids in a timely manner to 1 of 2 residents (R15) reviewed for communication. Findings include: R15's quarterly Minimum Data Set (MDS) dated 3/6/18, identified R15 was cognitively intact, had adequate hearing, and wore hearing aids. R15's care plan dated 9/5/17, did not address hearing aid use. On 4/2/18, at 2:58 p.m. R15 was interviewed and stated she gave her hearing aids to the nursing assistants at night to be stored on the medication cart. R15 continued to state that this past week,	F 676	Cook Hospital and Care Center as reviewed the facility policies on Quality of Care and Quality of Life. We have found that these policies follow regulatory guidelines including resident expectation for a functional communication system and the use of it. We feel our policies were not followed and the ability to document the use of hearing aides was made challenging to our staff. An immediate audit of residents with hearing aides was conducted with the communication device. R15 has been immediately checked for hearing aide usage and will maintain compliance through staff education and audit. Staff will be educated beginning May 1	

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F 676	Continued From page 5 she went four days without her hearing aids. R15 stated she had requested them several times, and was told by the nurses they would bring them, and then never did. R15 had her hearing aids in at the time of the interview, however she voiced concerns the batteries were dead, and she was having difficulty hearing. On 4/3/18, at 4:07 p.m. nursing assistant (NA)-A stated R15 did not always have her hearing aids in when she started her evening shift, and at times NA-A had to request them from the nurse. NA-A stated the nurses kept the hearing aids on the medication cart, and they were responsible to give residents their hearing aids in the morning. On 4/4/18, at 7:56 a.m. R15 left her room via wheelchair, went to the dining room, and sat at the counter for breakfast. R15 did not have her hearing aids in. On 4/4/18, At 8:33 a.m. registered nurse (RN)-B handed R15's hearing aids to the nurse in training. The nurse in training brought the hearing aids to R15, and assisted her with placing them. On 4/4/18, at 9:24 a.m. NA-B stated the nurse was responsible for giving residents their hearing aids, because they were on the medication cart for safety. Further, NA-B stated R15 did report to her she went without her hearing aids for four days. R15's daughter had also brought up concerns about R15 not receiving her hearing aids right away in the morning. On 4/4/18, at 9:46 a.m. RN-B stated all residents hearing aids were stored on the medication cart. Sometimes the nursing assistants asked for them; otherwise the hearing aids were usually	F 676	2018 and be complete by May 15 to ensure all staff have the process in place. Procedural change was implemented 04/30/18 as follows: *Evening shift nursing will bring individual hearing aide containers marked with resident name to nurse aide station. *Nurse aide will take the container and place resident hearing aide in container after checking for damage. *Nurse will bring containers to the medication locked cart for storage. *following morning or as resident desires, the container will be brought to nurse aide station and then given to residents. *IT department created an intervention in our Meditech EMR system for availability to document the removal and placement of the hearing aides. There is also an other column for those times when hearing aide is not placed due to unforeseen circumstances. An audit of 3 residents per week for 6 weeks will take place by director of nursing or designee to follow compliance of this procedure change. The director of nursing is responsible for implementation of these procedural changes.	

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F 676	Continued From page 6	F 676		

given when she administered their medication. RN-B stated they did not document when residents received their hearing aids, or when they were returned to the medication cart. RN-B stated at times residents don't receive their hearing aids at all, because the nurse may forget, or the hearing aids were not returned to the medication cart the night before. RN-B continued to state many times residents, including R15, don't receive their hearing aids until noon. RN-B felt the residents should receive them when they get up.

On 4/4/18, at 10:09 a.m. RN-D stated there were problems with residents getting their hearing aids timely. RN-D stated there should be documentation of when R15 received her hearing aids. RN-D reviewed R15's medical record, hearing aid use was not on the care plan and should be.

On 4/4/18, at 2:28 p.m. family member (FM)-B stated there were ongoing issues with R15 receiving her hearing aids, and when she did receive them, the batteries were frequently dead.

On 4/5/18, at 10:40 a.m. R15 was observed not to have hearing aids in.

At 11:02 a.m. RN-E stated hearing aids were given in the morning to residents, with their morning medications. RN-E stated he did not look to see if R15 had her hearing aids in the medication cart that morning. RN-E checked the medication cart, and stated the hearing aids were not on the cart. RN-E stated it was the medication nurses responsibility to ensure the resident had their hearing aids, the hearing aids were placed in the residents ears if they wanted them, and

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F 676	Continued From page 7 ensure the hearing aids were not missing. A policy on hearing aid use was requested and not received.	F 676		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced	F 726		5/15/18

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F 726	Continued From page 8	F 726		

by:
Based on observation, interview, and document review, the facility failed to ensure nursing staff were trained and assessed for competency regarding crushing medications without an order for 2 of 8 residents (R11, R19) and administration of eye drops using appropriate hand hygiene and techniques to prevent cross contamination for 1 of 1 resident (R11) observed for eye drop administration.

Findings include:

R11's History and Physical dated 7/10/17, indicated R11's diagnoses included chronic pain, macular degeneration and esophageal strictures.

R11's signed physician orders dated 2/23/18, included orders for Ocuvite with Lutein (vitamin to support eye health) one tab by mouth (po) twice daily, Ultram (pain medication) 50 milligrams (mg) po three times daily, Aleve (nonsteroidal anti-inflammatory) 220 mg po twice daily, and Artificial Tears eyedrops, instill 1 drop into both eyes four times daily. R11's orders lack directions to crush medications.

On 4/2/18, at 5:37 p.m. registered nurse (RN)-A was observed during medication pass. RN-A crushed R11's naproxen sodium (Aleve), I-vite (for Ocuvite), and tramadol (Ultram) medications prior to administration of these medications. RN-A administered the crushed medications in applesauce to R11. RN-A stated R11 has medications crushed, but did not know if R11 had an order for crushing medications. RN-A stated the medications were okay to crush as far as she knew.

The Cook Hospital and Care Center has a medication administration policy that was, after review, found to be lacking in addressing the component of crushing of medication together for our residents. The policy did have proper medication administration technique.
In review of resident vital signs, nurse documentation and physician progress note, no ill effects were found in R11 or R19 when medications were crushed together or in R19 with improper hand hygiene in eye drop administration.
Competent staff is the goal of the facility for quality resident care. The Cook Care Center has implemented a new competency program that will take effect 5/15/18 for nursing staff and the nurse aide group. Staff will be educated on this competency during the 1st week of May 2018. It will consist of best-practice competency in physical, mental and psychosocial well-being. Nursing staff will be trained on proper medication administration including but not limited to administration of medication that needs to be crushed, physician orders, individual crushing and administration of a medication, proper hand hygiene and administration of ophthalmic drops for residents. Training for nursing staff will be complete by May 15 2018. Annual competency checklist in a re-vamped form has been implemented for start date of May 15 2018. Competency includes specific skills for resident care, an evaluation of the skill, whether the staff member demonstrated the skill or needs

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F 726	Continued From page 9 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, which he took without difficulty. RN-B prepared oral medications and eye drops at the medication cart. RN-B did not wash hands prior to medication administration. RN-B administered R11's oral medication first. RN-B then held R11's right eye open, touching the outside of his eyelid with her ungloved left hand, and administered a drop of artificial tears into the right eye while touching the tip of eye drop bottle to R11's eyelid. RN-B repeated the practice on R11's left eye, again touching the tip of the eye drop bottle to R11's eyelid. RN-B returned to the medication cart, manipulated items on the cart, and opened the cart drawer. When asked about wearing gloves during eye drop administration, RN-B stated she wore gloves, "Sometimes." RN-B put away the eye drops in the medication cart, and documented on the computer. When asked about washing or sanitizing hands following administration of eye drops and touching a resident's eyes, RN-B stated she washes or sanitizes her hands after she is done documenting on the computer. RN-B stated she should have sanitized her hands right away, after eye drop administration.	F 726	further training, the method of evaluation (demonstration, observation, written test or verbal test) and staff member who verified competency and date. We have now had the opportunity to have Medbridge join our team in staff education. We have partnered with Medbridge and will utilize their expertise in the following staff education: Wound Care Series: " Assessment and Documentation of Pressure Injuries " Assessment and Management of Lower Extremity Ulcers " Prevention of Pressure Injuries (for Nursing Assistants) " Prevention of Pressure Injuries: Risk Assessment and Care Planning " Topical Management of Pressure Injuries " Utilizing QAPI for Building an Effective Pressure Injury Program Fall Prevention Series: " Falls Series: Introduction to Root Cause Analysis " Falls Series: Applying Root Cause Analysis to Falls " Falls Series: Causation of Resident Falls " Falls Series: Falls Solutions & Interventions Infection Prevention Series: " Sepsis: Early Recognition to Avoid Rehospitalization " Creating an Antibiotic Stewardship Program " The Role of the Infection Preventionist in Long-Term Care Dementia Series: " How to Communication When Someone	

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F 726	Continued From page 10 R19's History and Physical dated 6/28/17, indicated R19's diagnoses included Alzheimer's disease and osteopenia (bone loss) with a history of related fractures. R19's signed Physician Orders dated 3/28/18, included orders for Tylenol (acetaminophen) 650 mg po four times daily for arthritis. R19's diet order was NDDI (pureed). R19's physician orders lacked orders to crush medications. On 4/3/18, at 11:54 a.m. RN-B crushed R19's acetaminophen, and administered it in applesauce to R19. RN-B stated she thought R19 had an order to crush medications. On 4/4/18, at 8:21 a.m. RN-B stated they have not received training on crushing medications. RN-B stated they get orders for crushing medications or concealing medications. RN-B stated she had received training on administering eye drops, but she just did not do it correctly yesterday. RN-A's skills checklist dated 5/20/17, indicated RN-A had been trained in medication administration, but lacked training in crushing of medications. RN-B's orientation checklist dated 2/9/16, included training and return demonstration on hand hygiene, and training on infection control. RN-B's checklist lacked training regarding crushing of medications. On 4/4/18, at 11:00 a.m. the director of nursing (DON) was interviewed and verified medications were not to be crushed without a physician's order. The DON verified they have not trained	F 726	is Living with Dementia " Working with Dementia: Understand Changes in Movement and Sensation " Depression, Delirium, Dementia: The 3 D's in a Complex Patient " Untangling Depression, Delirium and Dementia: Screening and Assessment Strategies " Key Indicators of Primary Dementias and How They Fit Together " Overview of Psychosocial Issues " Management of Aggressive Behavior The director of nursing or designee will observe 3 medication passes per week for 6 weeks and observation results will be updated at IDT meetings 2 times per week and at facility QAPI. The director of nursing or designee will audit 3 medication passes within Meditech EMR for proper documentation and observation of the resident rights of safe medication administration. The results will be updated at IDT 2 times per week and at facility QAPI. The director of nursing or designee will observe 3 medication passes per week for 6 weeks for compliance of crushing of medications safely and effectively per regulations and procedure. The observation results will be updated at IDT 2 times per week and at facility QAPI. The director of nursing is responsible for the compliance of this regulation process.	

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F 726	Continued From page 11 licensed nurses on this yet. The DON verified nurses should wash hands and glove prior to administration of eye drops, then instill eye drops without touching the eye drop bottle to the eye lid. The DON stated nurses should remove gloves and sanitize or wash hands immediately after administration of eye drops. The facility policy Administration of Medication in Long Term Care dated 4/13/17, directed nursing to crush medications when necessary according to physician orders, manufacturer's information, the pharmacist, and drug reference. The policy further directed medications may be crushed together unless contraindicated by physician order, manufacturer's information, or accepted principles and standards. The facility policy Hand Hygiene revised 1/18, directed hand hygiene to be done before and after each resident contact, and wash hands with soap and water prior to setting up medication and prior to passing out medication, and in between resident medication administration.	F 726		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure meaningful activities were provided to 3 of 4 residents (R1, R17, R16) reviewed for dementia care.	F 744	The Cook Care Center has found that we do not have a specific policy on dementia other than what is in our vulnerable adult policy. We have immediately created	5/15/18

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F 744	Continued From page 12 Findings include: R1's History and Physical dated 1/31/18, indicated R1's diagnoses included severe dementia, agitation, mood instability, and chronic pain, and required extensive to full assist with activities of daily living. R1's quarterly Minimum Data Set (MDS) dated 2/5/18, indicated R1 sometimes understood others and was sometimes understood by others, had severely impaired cognitive skills for decision-making, had delusions and had no rejection of cares. R1's MDS further indicated R1 had physical, verbal and wandering behaviors 1 to 3 days during the assessment period. R1's annual MDS dated 11/9/17, indicated it was somewhat important to R1 to listen to music, be around animals, do things with groups of people, and go outside. R1's Care Area Assessments (CAA) dated 11/15/17, for cognitive loss/dementia indicated R1 propelled own wheelchair around the care center, had a moderately impaired cognitive impairment, and was able to make simple daily decisions. R1's cognitive loss CAA indicated R1 had difficulty focusing attention, and was easily distracted. R1's CAA for psychosocial well-being indicated R1 did not answer questions regarding importance of participation in favorite activities, and had variable moods during activities. R1's CAA indicated R1 would stay and observe activities for approximately 45 minutes, or would watch game shows on the television. R1 spent time wandering in hallways, holding a doll, visiting with staff, watching tv and attending activities.	F 744	policy Behavioral Health LTC which will be reviewed 04/30/18 at IDT and sent to Medical Staffing for approval the week of May 7. Once approved staff education will take place the same week with completion by May 15 2018. The policy is specific to care of behaviors including but not limited to residents with dementia and cognitive disability. The goal of the Cook Care Center is to give our residents quality of life regardless of resident ability. Staff education and competency is the key in quality care of our dementia residents. We have teamed up with Medbridge to assist us in our staff education and will consist of: Dementia Series: " How to Communication When Someone is Living with Dementia " Working with Dementia: Understand Changes in Movement and Sensation " Depression, Delirium, Dementia: The 3 D's in a Complex Patient " Untangling Depression, Delirium and Dementia: Screening and Assessment Strategies " Key Indicators of Primary Dementias and How They Fit Together Psychosocial Issues Series: " Overview of Psychosocial Issues " Management of Aggressive Behavior An immediate audit of our residents clarified we have 9 other residents potentially affected by lack of meaningful activities. Residents R1, R17, R16 have had Activities Assessments completed 4/30/18. The 9 dementia residents as	

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F 744	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 in exercise, tv, walking with resident/sitting with staff -on 4/1/18, in the afternoon R1 spent 360 minutes in a 1:1 visit, coffee group, and observing others -on 3/31/18, in the afternoon R1 spent 360 minutes in a 1:1 visit, coffee group, and observing others	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 as organizing books, sorting coins and silverware, decorating cookies and assisting with setting of tables. Recreational activities such as flipping through scrapbooks and magazines and dementia appropriate puzzles. Physical activity is limited due to R1, R16, R17 physical function. Education through Medbridge will start the second week of May 2018. Proper documentation is also a key factor 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 and involve 3 residents per week for 6 weeks. Observation will include monitoring of resident activities with cognitive impairment. The process will look to ensure proper compliance on meaningful activities for our residents. Results will be 2 times weekly at IDT and updated at QAPI. An audit of Meditech EMR documentation will take place on 2 residents a week for 6 weeks. The documentation will be monitored and updates to IDT will take place twice weekly and to the QAPI committee.	

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-on 3/30/18, in the evening, R1 spent 100 minutes reading/writing, tv/movies, with children, and a 1:1 visit
-on 3/30/18, in the morning, R1 spent time watching tv/movies, coffee group, and holding a doll and sitting with staff.

Further documentation indicated R1 participated in these activities one to two times daily for 60 minutes to 360 minutes each time. Documentation for the afternoon on 4/3/18, indicated R1 participated in coffee group and observing others for 180 minutes, and on the morning of 4/4/18, R1 participated in pet visits, and sitting with staff for 90 minutes.

On 4/2/18, at 6:15 p.m. R1 was observed wandering in the hallway and into others' rooms. The outside door alarm sounded and she was removed from the area. At 6:25 p.m. R1 was observed in the day area on the unit, smiling and conversing with others. Staff took her to her room at that time.

On 4/4/18, between 8:48 a.m. and 10:18 a.m. R1 was observed to eat breakfast, wander in the hallways on the unit, sit and look out the windows for over a half hour, then hold a doll and talk to the doll. An activity on the other unit at that time, included making ice cream.

On 4/4/18, at 10:06 a.m. nursing assistant (NA)-B stated R1 wandered, but has wandered less since moving to the new unit.

On 4/4/18, at 2:53 p.m. R1 was observed wandering in the hallways on the unit, and occasionally staff stopped to say hello, and continued on their way. R1 was holding the doll.

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In the common activity area, other residents were planting seeds. No pets were observed visiting with R1 during the day.

On 4/5/18, at 9:37 a.m. R1 was sitting quietly at the counter after eating her breakfast.

On 4/5/18, at 9:42 a.m. housekeeper (H)-A stated R1 has not had a bad day since moving the new unit. H-A stated R1 wandered less into others' rooms. H-A stated R1 liked her dolls and had three. H-A also stated R1 liked her stuffed cat, liked her nails done so activities will do her nails every so often, or they would do 1:1 visits with her. H-A stated R1 usually does not go to group activities because she wanders.

On 4/5/18, at 9:56 a.m. H-A brought R1 her stuffed cat and R1 talked to the cat, which was purring. R1 spent the morning on the unit, holding her cat and moving about the unit.

R17's History and Physical dated 12/19/17, indicated R17's diagnoses included a stroke, advanced Alzheimer's dementia, and depression. R17's History and Physical further addressed R17's dementia, and directed nursing to continue to do interventions to stimulate her, and encourage her to participate as able, and noted that R17 had been watching the Price is Right with other residents.

R17's quarterly MDS dated 12/21/17, indicated R17 had severely impaired cognitive skills for daily decision making, had symptoms of delirium, hallucinations, and physical and verbal behaviors 1-3 days during the assessment period. R17's MDS further indicated R17 required total assistance of staff with locomotion on the unit,

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and locomotion off the unit did not occur. R17's comprehensive MDS, in process during the survey, indicated R17 indicated it was very important for R17 to go outside when the weather was good, otherwise, activities listed were either not very important or not important at all to R17.

R17's CAA dated 4/3/18, for cognitive loss/dementia indicated R17 had severely impaired cognitive skills for daily decision making abilities, had symptoms of inattention and had disorganized thinking. R17's CAA for psychosocial well-being referred to the mood CAA which indicated R17 had no signs or symptoms of depression. R17's CAAs did not address activity participation.

R17's activity documentation indicated the following:
-on 4/5/18, in the morning R17 participated in exercise, visitors, and pet visits for 90 minutes.
-on 4/4/18, in the evening R17 participated in TV/movies and 1:1 visits for 30 minutes.
-on 4/4/18, in the morning, R17 participated in tv/movies for 45 minutes.
-on 4/3/18, in the later afternoon, R17 participated in tv/movies, 1:1 visits, coffee group, and the birds for 180 minutes.
-on 4/3/18, in the early afternoon, R17 participated in tv/movies, 1:1 visits coffee group, birds, observing others and "zzzzzz" (sleeping) for 180 minutes.
-on 4/2/18, in the evening R17 participated in tv/movies, 1:1 visits, coffee group, and observing others for 120 minutes.
-on 4/2/18, in the morning R17 participated in pet visits and coffee group for 45 minutes.
-on 4/1/18, in the afternoon R17 participated in tv/movies, 1:1 visits, observing others and "zzzzz"

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(sleeping) for 360 minutes.
Further activity documentation indicated R17 participated in these activities 1 to 2 times daily, for 30 to 360 minutes. Several entries included sleeping time, sitting in front of the TV, and observing others, without interaction as activities.

A review of R17's activity participation and the activity calendar for March 2018, indicated R17 was not taken to group activities, including BINGO on 3/17 and 3/31. The same was true in February 2018.

On 4/4/18, at 8:47 a.m. R17 was sitting quietly in the dining room and was assisted by staff to eat breakfast.

On 4/4/18, at 9:00 a.m. R17 was moved from the table to sit in front of the TV in the day area.

On 4/4/18, at 9:42 a.m. R17 was brought to her room, and at 10:01 a.m. she was brought down to the end of the hall to sit in the sunlight.

On 4/4/18, at 2:52 p.m. R17 was lying quietly in bed. There was an activity in the day area with residents planting seeds.

On 4/5/18, at 9:35 a.m. R17 was sitting in front of the TV on the unit, with her eyes closed, following breakfast. At 9:38 a.m. AD-A asked if she wanted to go out to sit in front of the birds with her friends, and R17 said she did. An NA first took R17 to her room for cares.

On 4/5/18, at 9:51 a.m. R17 was returned to the unit day area and placed in front of the TV, with closed eyes. R17 sat there alone, without other residents or staff in the area. At 9:54 a.m. activity

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director (AD)-A returned to the unit and left the unit without taking R17 to activities.

On 4/4/18, at 9:58 a.m. NA-B stated R17 displayed physical behaviors toward staff during cares, but R17's behaviors have decreased since moving to the new unit. NA-B stated they place R17 in the sun for 25 minutes daily. NA-B stated activities staff tend not to take R17, R1, and those residents who are unable to participate fully in activities, to group activities. NA-B stated the NAs have been trying to push their attendance in activities.

On 4/5/18, at 11:28 a.m. the director of nursing (DON) stated dementia activities were lacking, and verified there were no pet visits on the units on 4/4/18, as documented in R1's activity documentation. The DON stated activities for residents with dementia often included sitting in front of the birds and other such activities, which were not engaging them. The DON stated they were trying to revamp activities. The DON stated engaging R1 in activities would decrease her wandering into other rooms. The DON stated they do more baking and other activities in the evenings, and the nursing assistants on the unit are very good with R1.

On 4/5/18, at 11:44 a.m. activity director (AD)-A stated if residents were unable to participate in activities, he would take them to the group, the bird aviary, outside, do their nails, etc. AD-A stated bringing to the group activities is beneficial and verified they had not done 1:1 activities with R1 during observations. AD-A stated R1 usually comes to BINGO, and families sit with her. AD-A stated pet visits included everything, including the bird aviary. AD-A verified pets did not visit as

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F 744	Continued From page 19 documented. AD-A stated they make sure residents with dementia are seen by activities weekly. AD-A stated staff participate in dementia training and are scheduled to attend the training. AD-A stated R1 will hold a doll or her cat, and likes to sit with the staff when they are charting. AD-A stated R17 was brought to a quiet place, and they place her in the sun because she did that at home. AD-A stated they do not bring R17 to church, on bus trips or music programs, as music is noise to her. AD-A stated they do nails and lotions weekly for R1 and R17. AD-A stated 1:1 activities are not scheduled for them. The facility was unable to provide a policy on activities for residents with dementia.	F 744		

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R16's Face Sheet dated 3/19/18, indicated R16's diagnoses included altered mental status, major depressive disorder, and unspecified psychosis.

R16's History and Physical dated 1/26/18, indicated R16 resisted much of therapy, most of the time, and refused medication; resident is on very little.

R16's care plan reviewed 2/27/18, indicated R16 was at risk for impaired psychosocial wellbeing related to delusions that staff wanted to harm resident. Interventions included R16's preference to go to bed and get up when resident asked, establish a trusting relationship, and provide reassurance and comfort. The care plan also indicated a risk for impaired social interaction as R16 wanted to remain in a certain place most of the day, or in a recliner. The care plan noted R16 often yelled out when seen on a 1:1 basis. Interventions included providing a picture of R16 and spouse at meal table as this was where she preferred to sit throughout the day, offer coffee while she's sitting in the dining area, verbal reminders of activity times, bringing resident to activities using wheelchair, table games, encouragement to attend music programs, and active games. R16's goal was specified that she will observe the picture of spouse and self, three times daily (meals), and resident will accept 1:1 visits three times weekly.

R16's activity documentation records for the

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month of February 5, 2018, through April 4, 2018, consistently included combined recording of very general activities. Daily recordings for those 59 days included combined activities participated in as TV or movies, 1:1 visit, coffee group, observing others, and sleeping for lengths of time varying from 20 minutes to 360 minutes. All activities recorded 2/5/18, through 4/4/18, included 1:1 visit recorded 61 times, coffee group recorded 53 times (often more than once per day), observing others and/or sleeping recorded as an activity 38 times, TV or movies recorded 49 times, observing R16's picture recorded twice (though picture observed to be in front of R16 for each meals observed during survey), took R16 to x-ray recorded as an activity once, luncheon recorded once, party recorded once, children recorded once, pet visits recorded once, visitors recorded once, beauty shop recorded once, talked about dancing recorded once, read R16's mail to resident recorded once, and music activity recorded once.

April 3, 2018, activity documentation record for R16 at 1:08 p.m. included Activities Participated in today - TV or Movies, Coffee Group and Other Activities Not Listed of Sleeping for Amount of Time in Activity - 180 minutes. Activity documentation record dated April 3, 2018, at 3:27 p.m. listed Activities Participated in today as TV or Movies and Sleeping for 180 minutes. Reviewer noted that 180 minutes had not elapsed between activity staff recordings.

On 4/4/18, at 2:02 p.m. nursing assistant (NA)-E was interviewed. When asked if R16 had experienced changes in activity levels, NA-E stated R16 used to sit and watch activities but never participated. NA-E stated now R16 sits by

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 27 herself, and doesn't usually eat at the same time the other residents eat. On 4/4/18, at 2:04 p.m. NA-D stated she recently started working with R16, and had noted that R16 slept more during the day, especially if she had a rough night. On 4/4/18, at 2:04 p.m. NA-C stated that when she visits with R16 she didn't get as much response currently as she did previously. NA-C used to dance with R16 by taking her hands while she was in a wheelchair. NA-C stated she had joked with R16 and had fun, but R16 doesn't do that anymore. NA-C noted that R16 slept more now as part of the decline of aging. The facility's undated Alzheimer's Disease and Dementia training materials provided did not include information on meaningful activities for residents with dementia.	F 744		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph	F 756		4/30/18

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F 756	Continued From page 28 (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure pharmacy recommendations were reviewed by the director of nursing (DON) and medical director (MD) for 5 of 5 residents (R9, R27, R6, R3, and R16). In addition, the facility failed to ensure pharmacist recommendations were responded to timely for 1 of 5 residents (R3) reviewed for unnecessary medications. Findings include: R9's Face Sheet indicated R9's diagnoses included acute kidney failure, dementia,	F 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: While surveyors were on site we changed our process and procedure to ensure the physician was aware of pharmacy recommendations and director of nursing or designee was following up with the compliance. R9, R27, R6, R6, R3, R16 were found to	

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F 756	Continued From page 29 hypothyroidism, and atherosclerotic heart disease. R9's quarterly Minimum Data Set (MDS) dated 1/17/18, indicated R9 was cognitively intact, had mood symptoms, hallucinations, anxiety, depression and pain. R9's MDS further indicated R9 received antipsychotic, antianxiety, antidepressant, anticoagulant, diuretic, and opioid medications during the assessment period. R9's Physician Orders included orders for medications that included dementia medications, pain medications including opioids, antipsychotic medications, anticoagulant medications, diuretic medications, thyroid medications, blood pressure medications, antianxiety medications, antidepressant medications, respiratory medications, and sleep aid medications. R9's monthly consultant pharmacist reviews included several recommentations requiring review and follow up by the physician. R9's pharmacy consultant recommendations were reviewed and followed up on by R9's physician, but lacked review by the DON and the medical director. R27's Face Sheet indicated R27's diagnoses included acute kidney failure, anemia, pain, wheezing, and terminal atrophy of the kidney. R27's annual MDS dated 1/14/18, indicated R27 was cognitively intact, had mild symptoms of depression, depression, pain affecting sleep and daily activities, and received an antidepressant and diuretic medication. R27's Physician Orders for medications included	F 756	have no negative effects in their health. A chart audit with documentation and vitals signs was reviewed along with physician updates. *Pharmacy department (on site) makes recommendations to physicians based on best-practice for resident care. This takes place prior to physician monthly rounds of residents. *Pharmacy recommendation is placed with rounding documentation for the physician to view. We will continue the 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 and resident and family discussion. *Physician will document in Meditech EMR or residents Progress Note which will include the pharmacy recommendations and how the physician adjusted a medication regimen or not. *Agenda item has been added to IDT as pharmacy recommendations. This will be a standing agenda item. The rounds that take place that week will be monitored for physician follow up to the recommendations and will not come off IDT list until documentation of recommendation is complete in the history and physical or Progress Note. The director of nursing or designee will monitor and audit all pharmacy recommendations and physician follow up for completeness and regulatory compliance. The IDT meetings are already part of this procedure change and	

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F 756	Continued From page 30 antidepressant medications, pain medications, blood pressure medications, and diuretic medications. R27's monthly consultant pharmacist reviews included several recommentations requiring review and follow up by the physician. R27's pharmacy consultant recommendations were reviewed and followed up on by R27's physician, but lacked review by the DON and the medical director. R6's quarterly MDS dated 3/13/18, identified diagnoses of high blood pressure, high cholesterol, and depression. Medications included antipsychotic medications, antidepressant medications, and diuretic medications. R6's monthly consultant pharmacist reviews included recommendations requiring review and follow up by the physician. R6's pharmacy consultant recommendations were reviewed and followed up on by R6's physician; however, lacked review from the DON and the MD. R3's quarterly MDS dated 1/6/18, identified diagnoses of high blood pressure and high cholesterol. R3's Physician Order Sheet dated 3/27/18, identified orders for blood pressure medications	F 756	result updates will be given at facility QAPI. The director of nursing is responsible for compliance of this regulation.	

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F 756	Continued From page 31	F 756		

including Norvasc, Apresoline, Zestril, Lopressor. The Physician Order Sheet identified an order for Lipitor for high cholesterol.

R3's pharmacy medication reviews identified the following recommendations:

- 11/24/17, the consulting pharmacist recommended the physician to clarify the frequency of R3's blood pressure checks.

- 12/7/17, the consulting pharmacist recommended checking R3's fasting lipid panel (lab to check cholesterol levels) to ensure appropriate therapy. The last fasting lipid panel was completed October of 2016.

The physician did not address the 11/24/17, and the 12/7/17, consulting pharmacist recommendations in writing, nor were the recommendations reviewed by the DON or MD.

On 4/5/18, at 1:14 p.m. registered nurse (RN)-D stated it had been a year and half since R3 had a lipid panel completed. The physician failed to address ordering the lipid panel or justification for not ordering it. In addition, the physician failed to address how often R3's blood pressure should be checked. R3 did not have a specific order for frequency of blood pressure checks and received them weekly and as needed. The current process for pharmacy consult recommendations included the pharmacist completing the recommendations in the medical record. They were then printed and given to her self or a designee to place in the physicians rounding forms to address. There was not a current process to ensure the physician follows up on the recommendations.
At 1:24 p.m. the director of nursing (DON) stated

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he did not review the pharmacy consults recommendations and the MD did not review them either. The DON stated it was a challenge to get the physicians to address all the identified recommendations. There was not a current process to ensure the physician addressed the recommendations.
At 2:58 p.m. the consulting pharmacist (CP) stated she sends the irregularities and recommendations to the DON and MD. If she needed an immediate response from a physician, she would go to the physician herself. The CP stated she felt she gets a timely response on her recommendations, and the physician's approve 90 percent of them.
The facility policy Care Center Medication Review dated 2017, directed when the pharmacist discovered an irregularity it would be documented in the residents medical record and printed and forwarded to the physician for review. All irregularities and recommendations would be added to a spread sheet in the pharmacy, which would be used for follow up. The recommendations would be reviewed quarterly for completion and if appropriate re-submitted to the physician. A report would be generated at the end of the month. The report would include all irregularities and recommendations and would be sent to the director of nursing and medical staff director for review.

R16's Face Sheet dated 3/19/18, identified diagnoses that included altered mental status, edema, essential hypertension, hypokalemia (blood potassium levels are too low), major depressive disorder, and unspecified psychosis.

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R16's consultant pharmacist monthly review note 9/15/17, included: Medication review for August: Recommend checking potassium level because of diuretic therapy for edema. Last level was in February 2017.

R16's consultant pharmacist monthly review dated 10/16/17, included: Medication review for September: Mirtazapine due for a gradual dose reduction or documentation why it is not appropriate. Recommend rechecking potassium level due to diuretic use; last level is from February 2017.

R16's consultant pharmacist monthly review note 11/10/17, included: Medication review for October: Recommend rechecking a potassium level as furosemide is expected to lower it. Last level is from February 2017.

R16's MD notes dated 10/31/17, 11/09/17, and 12/22/17, lacked an order to check for a potassium level.

On 4/5/18, at 2:25 p.m. the DON stated when the pharmacist puts in a recommendation, the recommendation gets printed out,and goes to nursing. During the monthly resident MD rounds, the physician sees the recommendation, and he would expect the MD act upon it. The DON stated that the facility lacked a process for the DON and other nurses to see the consultant pharmacist recommendations, and see any action the physician took on the recommendations. The DON stated the MD doing the monthly rounding should respond to the consultant pharmacist's recommendations within a week or even at the next monthly review. The DON stated they do not have a system in place to

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F 756	Continued From page 34 make sure the physician responds to the consultant pharmacist's recommendations.	F 756		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were not crushed without a physician's order for 2 of 9 residents (R11, R19) observed for medication administration. This resulted in a medication error rate of 14%. Findings include: R11's History and Physical dated 7/10/17, indicated R11's diagnoses included chronic pain, macular degeneration and esophageal strictures. R11's signed Physician Orders dated 2/23/18, included orders for: Occuvite with Lutein (vitamin to support eye health) one tab po (by mouth) twice daily, Ultram (pain medication) 50 milligrams (mg) po three times daily, Aleve (nonsteroidal anti-inflammatory) 220 mg po twice daily. R11's orders lack directives to crush medications. On 4/2/18, at 5:37 p.m. during observation of medication pass, registered nurse (RN)-A crushed R11's naproxen sodium (Aleve), Occuvite, and tramadol (Ultram) medications	F 759	The Cook Hospital and Care Center has a medication administration policy that was, after review, found to be lacking in addressing the component of crushing of medication together for our residents. The policy did have proper medication administration technique. Competent staff is the goal of the facility for quality resident care. In review of resident vitals signs, nurse documentation and physician progress note, no ill effects on R11 when medication was crushed together or with R19 when eye drops were given without proper hand hygiene. Physician orders have been obtained on R11 and R19. In an immediate resident audit, 10 residents receive their medication crushed. A physician order is in place to crush the medications on all residents checked. In an immediate audit 5 other residents receive eye drops. No illness has been found on any of those residents after a chart review and audit of vital signs, nurse note and physician progress note. The Cook Care Center has implemented	5/15/18

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F 759	Continued From page 35 prior to administration of these medications. RN-A administered the crushed medication in applesauce to R11. RN-A stated R11 has medications crushed, but did not know if R11 had an order for crushing medications. RN-A stated the medications were okay to crush as far as she knew. 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. during observation of medication pass, RN-B stated that for the most part, they give R11's 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 3 spoonfuls. RN-B proceeded to administer R11 tramadol whole in applesauce, which he took without difficulty. R19's History and Physical dated 6/28/17, indicated R19's diagnoses included Alzheimer's and osteopenia (bone loss) with a history of related fractures. R19's signed Physician Orders dated 3/28/18, included orders for Tylenol (acetaminophen) 650 mg po four times daily for arthritis. R19's physician orders lacked orders to crush medications. On 4/3/18, at 11:54 a.m. RN-B crushed R19's acetaminophen, and administered it in applesauce to R19. RN-B incorrectly stated R19 had an order to crush medications. On 4/4/18, at 11:00 a.m. director of nursing	F 759	a new competency program that will take effect 5/15/18 for nursing staff and the nurse aide group. Staff will be educated on this competency during the 1st week of May 2018. It will consist of best-practice competency in physical, mental and psychosocial well-being. Nursing staff will be trained on proper medication administration including but not limited to administration of medication that needs to be crushed, physician orders, individual crushing and administration of a medication, proper hand hygiene and administration of ophthalmic drops for residents. Training for nursing staff will be complete by May 15 2018. Annual competency checklist in a re-vamped for has been implemented for start date of May 15 2018. Competency includes specific skills for resident care, an evaluation of the skill, whether the staff member demonstrated the skill or needs further training, the method of evaluation (demonstration, observation, written test or verbal test) and staff member who verified competency and date. Nurse staff education will take place the 2nd week of May 2018. The education will involve administration of medication and proper hygiene during medication pass. Best-practice will be used for staff education and compliance of regulatory standards will be re-enforced. Observation of medication administration will be performed 3 times weekly for 6 weeks for compliance regulatory standards. Updates will be given 2 times per week at IDT and at facility QAPI. Audits will take place on 3 residents	

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F 759	Continued From page 36 (DON) verified medications were not to be crushed without a physician's orders. The facility policy Administration of Medication in Long Term Care dated 4/13/17, directed nursing to crush pills when necessary according to physician orders, manufacturer's information, pharmacist, and drug reference. The policy and procedure further indicated medications may be crushed together unless contraindicated by physician order, manufacturers information or accepted principles and standards.	F 759	weekly for 6 weeks to check Meditech EMR for compliance and accuracy of documentation of medication administration. These results will be updated at IDT 2 times a week and at facility QAPI. The director of nursing is responsible for compliance of this regulation.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		5/15/18

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F 880	Continued From page 37 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 38 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to 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 adjusted and lowered the bed, and positioned R4 with pillows between her legs. R4 then removed the plastic bag with the soiled incontinent brief from the trash can, set it on the floor, and replaced the plastic bag with a clean one. NA-D replaced the sling on the chair and then went to R4's bathroom and washed her hands with soap and water. Immediately after R4's cares were	F 880	In a review of the Cook Care Center Infection Prevention Plan policy we agree that there is a lack of written analysis of infections which would identify trends or concerns. This policy was immediately updated to add a process by which the Infection Preventionist will follow trends on resident infection to allow more timely response as needed. We also reviewed the policy on hand hygiene. We focused on resident cares and medication administration. In our review we have found that the process and procedure are in place, however it was not being followed by staff. In review of resident charts including vital signs, nurse notes and physician rounds we have found no ill effects on resident R4 from improper hand hygiene or during administration of eye drops to R11. For the more timely monitoring of infections on our residents we have added a standing agenda item to IDT meeting twice weekly. Infection prevention nurse will monitor and trend all infections, new or continuing and antibiotic orders and usage. Monthly an update will be given to IDT for any unusual trends seen in our residents. Infection prevention nurse will audit all resident documentation on infections and antibiotics. These trends will be given to QAPI team quarterly as well as the monthly trends and twice weekly updates at IDT on infections and antibiotic use.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 39 completed, NA-D confirmed she did not wash her hands after she completed incontinence cares for R4. NA-D stated that she usually did not wash or sanitize her hands until the end of the process (completion of personal cares) with R4 because she did not want to leave R4 with her bed raised. NA-D stated she forgot to wash her hands, and she did not carry sanitizer in her pocket. NA-D stated she did not know whether she had been trained to sanitize or wash her hands immediately after removing a soiled incontinent brief. On 4/5/18, at 10:11 a.m. the assistant director of nursing (ADON) stated she expected staff to wash their hands after removing soiled gloves, and before moving on to other tasks. The ADON stated that she had pocket sized hand sanitizers available to staff for use. The ADON stated if she saw a staff member fail to wash their hands, she would stop and educate staff in the moment. The ADON restated her expectation that hands are to be washed after removing soiled gloves, before moving on to other tasks. The facility Hand Hygiene policy dated January 2018, directed hand hygiene was to be performed before and after direct contact with a resident, after gloving, after engaging in acts of personal hygiene for residents, and other situations. R11's signed physician orders dated 2/23/18, included orders for Artificial Tears eye drops, instill 1 drop into both eyes four times daily. On 4/3/18, at 11:43 p.m. RN-B was observed for medication pass. RN-B prepared oral medications and eye drops at the medication cart. RN-B did not wash hands prior to medication administration. RN-B administered R11's oral	F 880	Infection prevention nurse will educate staff starting May 1 2018 in a hands on hand hygiene training and return demonstration. This re-education will be complete the second week of May to have all staff given the training. Annual infection prevention education will continue through the infection prevention nurse. Infection prevention nurse will monitor announced 3 staff per week during resident care on the proper compliance of hand hygiene. Audits will take place for 6 weeks. The results will be updated weekly at IDT and at facility QAPI. Director of nursing or designee will audit 2 medication passes per week including ophthalmic drop placement for compliance of proper hand hygiene and compliance of policy. These audits will be for 6 weeks and be updated at IDT and QAPI. The director of nursing is responsible for the regulatory compliance of these processes.	

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	245392	A. BUILDING _____ B. WING _____	04/05/2018

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F 880	Continued From page 40	F 880		

medication first. RN-B then held R11's right eye open, touching the outside of his eyelid with her ungloved left hand, and administered a drop of artificial tears into the right eye while touching the tip of eye drop bottle to R11's eyelid. RN-B repeated the practice on R11's left eye, again touching the tip of the eye drop bottle to R11's eyelid. RN-B returned to the medication cart, manipulated items on the cart, and opened the cart drawer. When asked about wearing gloves during eye drop administration, RN-B stated she wore gloves, "Sometimes." RN-B put away the eye drops in the medication cart, and documented on the computer. When asked about washing or sanitizing hands following administration of eye drops and touching a resident's eyes, RN-B stated she washes or sanitizes her hands after she is done documenting on the computer. RN-B stated she should have sanitized her hands right away, after eye drop administration.

On 4/4/18, at 11:00 a.m. the director of nursing (DON) verified nurses should wash hands and glove prior to administration of eye drops, then instill eye drops without touching the eye drop bottle to the eye lid. The DON stated nurses should remove gloves and sanitize or wash hands immediately after administration of eye drops.

The facility policy Hand Hygiene revised 1/18, directed hand hygiene to be done before and after each resident contact, and wash hands with soap and water prior to setting up medication and prior to passing out medication, and in between resident medication administration.

The December 2017, infection surveillance log

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F 880	Continued From page 41	F 880		

included three urinary tract infections (culture results were not included on the log), one scalp infection, and one case of pneumonia. The facility lacked a written analysis of the infections to include if the urinary tract infections were related, or if interventions were implemented to reduce urinary tract infections.

The January 2018, infection surveillance log included four urinary tract infections. The organisms causing the infections included three E. coli and one E. faecium. The facility lacked a written analysis of the infections to include if the urinary tract infections were related, or if interventions were implemented to reduce urinary tract infections.

The February 2018, infection surveillance log included one urinary tract infection caused by E. coli, one skin infection and one case of pneumonia. The facility lacked a written analysis of the infections.

On 4/5/18, at 1:32 p.m. registered nurse (RN)-C (the facility infection preventionist), stated in January of 2018 the facility changed how they logged infections. From January on, they included all organisms for cultures. RN-C stated she reported only the number and type of infections to the infection control meeting every three months, and currently did not do a written analysis of the infections in the facility. The purpose for a written analysis was to look for trends and patterns of infections, and if any were noted, education or changes in their system could be made.

The facility Infection Prevention Plan/Surveillance for Hospital Care Center dated 12/16, directed trends or concerns are communicated to

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F 880	Continued From page 42 necessary care center personnel as appropriate. The policy did not identify completing a written analysis monthly to identify trends or concerns.	F 880		

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	245392	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/04/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Cook Hospital C & NC was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:	K 000	EPOC	

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

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K 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Cook Hospital C & NC is a 1-story building with a partial basement. The original building was constructed in 1960 with additions in 1966, 2000, 2005, and 2017. The original 1960 building and the 1966, 2000, and 2005 additions are all Type II (111) construction. The 2017 addition was determined to be of Type II(000) construction. The original building and all of the additions including the 2017 which had plans approved prior to July 5, 2016 were considered existing building for inspection purposes and the facility was inspected as 1 building. The building is fully fire sprinkler protected.. The facility has a complete fire alarm system with	K 000		

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K 000	Continued From page 2 smoke detection in spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 28 beds and had a census of 28 at the time of the survey. The requirement at 42 CFR, Subpart 485.623 (d) is NOT MET.	K 000		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct several fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.1.6, during the last 12-month period. This deficient practice could affect 28 of 28 residents, as well as an undetermined number of staff, and visitors. Findings include:	K 712	Fire drills were added to the Maintenance Supervisor's calendar for the year. They will be performed on those dates and supervisor will not let anything else interfere with the fire drill process. QAPI will be started and monitored every quarter for 2018. Fire drills required per LSC have been performed.	4/27/18

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K 712	Continued From page 3 On facility tour between 11:30 a.m. to 2:30 p.m. on 04/04/2018, during the review of all available fire drill documentation and interview with a Maintenance Supervisor revealed that the facility did not conduct 1 overnight shift fire drill in the third quarter. This deficient condition was confirmed by a Maintenance Supervisor.	K 712		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice could affect 28 of 28 residents, as well as an undetermined number of staff, and visitors. Findings include:	K 901	The Maintenance Supervisor will complete a Risk Assessment in accordance with the 2012 edition section 4.1. LSC NFPA 99 chapters 10, 11 and 12. A QAPI has been initiated. Annual auditing will be performed.	5/25/18

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K 901	Continued From page 4 On facility tour between 11:30 a.m. to 2:30 p.m. on 04/04/2018, during the documentation review and an interview with the Maintenance Supervisor it was revealed that the facility's risk assessment document did not account for all of the systems and equipment identified in chapter 10 and 11 of the NFPA 99 "Health Care Facilities Code" 2012 edition. This deficient condition was confirmed by the Maintenance Supervisor.	K 901		

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 only a suggestion 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. 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

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,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00586	A. BUILDING: _____ B. WING _____	04/05/2018

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On 4/2/18, through 4/5/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 375	MN Rule 4658.0200 Subp. 1 Policies Concerning Residents;Visitors Subpart 1. Visitors. A nursing home must provide access to a resident by relatives and guardians, and to any entity or individual that provides health, social, legal, advocacy, or religious services to the resident, subject to the resident's right to deny or withdraw consent at any time. A nursing home must also provide access to others who are visiting the resident with the resident's consent. A nursing home may restrict visits when the visits pose a health or safety risk to a resident or otherwise violate a resident's rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to allow residents visitation rights during an influenza outbreak. This had the potential to affect all 26 residents residing in the facility. Findings include: The Influenza-Like Illness Line List from 2/25/18, through 3/1/18, identified 11 residents with influenza-like symptoms. Three of the 11 residents had a confirmed Influenza A diagnosis. The first confirmed case of Influenza A was on 2/26/18. The Line List identified all 11 residents were placed on precautions, with the last day of a resident on precautions being 3/8/18. The	2 375	Corrected	5/15/18

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2 375	Continued From page 3 facility closed their doors to visitors from 2/26/18, through 3/12/18. On 4/2/18, at 6:27 p.m. R25 was interviewed, and stated she had to stay in her room for five days because of influenza. Further, R25 stated the facility would not allow any visitors, and then family members had complained. R25 stated the facility did not discuss with the residents about denying visitors, but told the residents they were not going to allow visitors. On 4/3/18, at 11:13 a.m. family member (FM)-A stated the facility called and notified her they were not allowing any visitors, because there was an influenza outbreak in the facility. FM-A stated she was not sure how long the restrictions lasted, but the facility had called and let her know when she could visit the facility again. At 1:28 p.m. during the resident council meeting R2, R9, R14, R25, and R27, all stated the facility administration shut down the facility to all visitors including family during an influenza outbreak. R25 added it was lonesome without visitors. On 4/4/18, at 10:09 a.m. registered nurse (RN)-D stated the facility policy directed to restrict visitors when there was an influenza outbreak; and it had been done in the past. Further, the families and residents were notified of the restrictions on visitation; however a few families became upset, and then the restrictions were removed. RN-D stated the restriction on visitors was not well received by the families, and the facility was trying to protect the residents. At 10:33 a.m. the director of nursing (DON) stated he did not even question the closing of the facility to visitors. He stated the facility infection	2 375		

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2 375	Continued From page 4 preventionist put the restrictions in place. After families complained, the restrictions were lifted. On 4/5/18, at 1:32 p.m. RN-C (the facility infection preventionist), stated she did some research, and thought it would be appropriate to restrict visitation to the facility during the facility's influenza outbreak. RN-C stated she did not take into account the resident's rights to have visitors. The facility policy Visitation in Long Term Care dated 1/10/17, identified the resident had the right, and the care center must provide immediate access per their wishes to family and non-family visitors. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and/or administrator or designee could develop, review, and/or revise policies and procedures to ensure residents' rights to visitation is upheld. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 375		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve	2 915		4/30/18

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2 915	Continued From page 5 abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide hearing aids in a timely manner to 1 of 2 residents (R15) reviewed for communication. Findings include: R15's quarterly Minimum Data Set (MDS) dated 3/6/18, identified R15 was cognitively intact, had adequate hearing, and wore hearing aids. R15's care plan dated 9/5/17, did not address hearing aid use. On 4/2/18, at 2:58 p.m. R15 was interviewed and stated she gave her hearing aids to the nursing assistants at night to be stored on the medication cart. R15 continued to state that this past week, she went four days without her hearing aids. R15 stated she had requested them several times, and was told by the nurses they would bring them, and then never did. R15 had her hearing	2 915	Corrected	

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2 915	Continued From page 6	2 915		

aids in at the time of the interview, however she voiced concerns the batteries were dead, and she was having difficulty hearing.

On 4/3/18, at 4:07 p.m. nursing assistant (NA)-A stated R15 did not always have her hearing aids in when she started her evening shift, and at times NA-A had to request them from the nurse. NA-A stated the nurses kept the hearing aids on the medication cart, and they were responsible to give residents their hearing aids in the morning.

On 4/4/18, at 7:56 a.m. R15 left her room via wheelchair, went to the dining room, and sat at the counter for breakfast. R15 did not have her hearing aids in.

On 4/4/18, At 8:33 a.m. registered nurse (RN)-B handed R15's hearing aids to the nurse in training. The nurse in training brought the hearing aids to R15, and assisted her with placing them.

On 4/4/18, at 9:24 a.m. NA-B stated the nurse was responsible for giving residents their hearing aids, because they were on the medication cart for safety. Further, NA-B stated R15 did report to her she went without her hearing aids for four days. R15's daughter had also brought up concerns about R15 not receiving her hearing aids right away in the morning.

On 4/4/18, at 9:46 a.m. RN-B stated all residents hearing aids were stored on the medication cart. Sometimes the nursing assistants asked for them; otherwise the hearing aids were usually given when she administered their medication. RN-B stated they did not document when residents received their hearing aids, or when they were returned to the medication cart. RN-B stated at times residents don't receive their

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2 915	Continued From page 7	2 915		

hearing aids at all, because the nurse may forget, or the hearing aids were not returned to the medication cart the night before. RN-B continued to state many times residents, including R15, don't receive their hearing aids until noon. RN-B felt the residents should receive them when they get up.

On 4/4/18, at 10:09 a.m. RN-D stated there were problems with residents getting their hearing aids timely. RN-D stated there should be documentation of when R15 received her hearing aids. RN-D reviewed R15's medical record, hearing aid use was not on the care plan and should be.

On 4/4/18, at 2:28 p.m. family member (FM)-B stated there were ongoing issues with R15 receiving her hearing aids, and when she did receive them, the batteries were frequently dead.

On 4/5/18, at 10:40 a.m. R15 was observed not to have hearing aids in.

At 11:02 a.m. RN-E stated hearing aids were given in the morning to residents, with their morning medications. RN-E stated he did not look to see if R15 had her hearing aids in the medication cart that morning. RN-E checked the medication cart, and stated the hearing aids were not on the cart. RN-E stated it was the medication nurses responsibility to ensure the resident had their hearing aids, the hearing aids were placed in the residents ears if they wanted them, and ensure the hearing aids were not missing.

A policy on hearing aid use was requested and not received.

SUGGESTED METHOD OF CORRECTION:

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2 915	Continued From page 8 The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure hearing aids are consistently provided and placed for residents who wear hearing aids. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815;	21390		5/15/18

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21390	Continued From page 9 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 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 adjusted and lowered the bed, and positioned R4 with pillows between her legs. R4 then removed	21390	Corrected	

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the plastic bag with the soiled incontinent brief from the trash can, set it on the floor, and replaced the plastic bag with a clean one. NA-D replaced the sling on the chair and then went to R4's bathroom and washed her hands with soap and water. Immediately after R4's cares were completed, NA-D confirmed she did not wash her hands after she completed incontinence cares for R4. NA-D stated that she usually did not wash or sanitize her hands until the end of the process (completion of personal cares) with R4 because she did not want to leave R4 with her bed raised. NA-D stated she forgot to wash her hands, and she did not carry sanitizer in her pocket. NA-D stated she did not know whether she had been trained to sanitize or wash her hands immediately after removing a soiled incontinent brief.

On 4/5/18, at 10:11 a.m. the assistant director of nursing (ADON) stated she expected staff to wash their hands after removing soiled gloves, and before moving on to other tasks. The ADON stated that she had pocket sized hand sanitizers available to staff for use. The ADON stated if she saw a staff member fail to wash their hands, she would stop and educate staff in the moment. The ADON restated her expectation that hands are to be washed after removing soiled gloves, before moving on to other tasks.

The facility Hand Hygiene policy dated January 2018, directed hand hygiene was to be performed before and after direct contact with a resident, after gloving, after engaging in acts of personal hygiene for residents, and other situations.

R11's signed physician orders dated 2/23/18, included orders for Artificial Tears eye drops, instill 1 drop into both eyes four times daily.

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21390	Continued From page 11 On 4/3/18, at 11:43 p.m. RN-B was observed for medication pass. RN-B prepared oral medications and eye drops at the medication cart. RN-B did not wash hands prior to medication administration. RN-B administered R11's oral medication first. RN-B then held R11's right eye open, touching the outside of his eyelid with her ungloved left hand, and administered a drop of artificial tears into the right eye while touching the tip of eye drop bottle to R11's eyelid. RN-B repeated the practice on R11's left eye, again touching the tip of the eye drop bottle to R11's eyelid. RN-B returned to the medication cart, manipulated items on the cart, and opened the cart drawer. When asked about wearing gloves during eye drop administration, RN-B stated she wore gloves, "Sometimes." RN-B put away the eye drops in the medication cart, and documented on the computer. When asked about washing or sanitizing hands following administration of eye drops and touching a resident's eyes, RN-B stated she washes or sanitizes her hands after she is done documenting on the computer. RN-B stated she should have sanitized her hands right away, after eye drop administration. On 4/4/18, at 11:00 a.m. the director of nursing (DON) verified nurses should wash hands and glove prior to administration of eye drops, then instill eye drops without touching the eye drop bottle to the eye lid. The DON stated nurses should remove gloves and sanitize or wash hands immediately after administration of eye drops. The facility policy Hand Hygiene revised 1/18, directed hand hygiene to be done before and after each resident contact, and wash hands with soap and water prior to setting up medication and	21390		

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21390	Continued From page 12 prior to passing out medication, and in between resident medication administration. The December 2017, infection surveillance log included three urinary tract infections (culture results were not included on the log), one scalp infection, and one case of pneumonia. The facility lacked a written analysis of the infections to include if the urinary tract infections were related, or if interventions were implemented to reduce urinary tract infections. The January 2018, infection surveillance log included four urinary tract infections. The organisms causing the infections included three E. coli and one E. faecium. The facility lacked a written analysis of the infections to include if the urinary tract infections were related, or if interventions were implemented to reduce urinary tract infections. The February 2018, infection surveillance log included one urinary tract infection caused by E. coli, one skin infection and one case of pneumonia. The facility lacked a written analysis of the infections. On 4/5/18, at 1:32 p.m. registered nurse (RN)-C (the facility infection preventionist), stated in January of 2018 the facility changed how they logged infections. From January on, they included all organisms for cultures. RN-C stated she reported only the number and type of infections to the infection control meeting every three months, and currently did not do a written analysis of the infections in the facility. The purpose for a written analysis was to look for trends and patterns of infections, and if any were noted, education or changes in their system could be made.	21390		

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21390	Continued From page 13 The facility Infection Prevention Plan/Surveillance for Hospital Care Center dated 12/16, directed trends or concerns are communicated to necessary care center personnel as appropriate. The policy did not identify completing a written analysis monthly to identify trends or concerns. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and infection preventionist or designee could develop, review, and/or revise policies and procedures to ensure an infection control program includes tracking and surveillance of antibiotic use when a physician's orders for antibiotics is received. The Director of Nursing, infection preventionist, or designee could develop, review, and/or revise policies and procedures to ensure proper hand hygiene practices during and following personal cares, and administration of eye drops. The Director of Nursing and infection preventionist or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing and infection preventionist or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological	21435		5/15/18

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21435	Continued From page 14 well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure meaningful activities were provided to 3 of 4 residents (R1, R17, R16) reviewed for dementia care. Findings include: R1's History and Physical dated 1/31/18, indicated R1's diagnoses included severe dementia, agitation, mood instability, and chronic pain, and required extensive to full assist with activities of daily living. R1's quarterly Minimum Data Set (MDS) dated 2/5/18, indicated R1 sometimes understood others and was sometimes understood by others, had severely impaired cognitive skills for decision-making, had delusions and had no rejection of cares. R1's MDS further indicated R1 had physical, verbal and wandering behaviors 1 to 3 days during the assessment period. R1's annual MDS dated 11/9/17, indicated it was somewhat important to R1 to listen to music, be around animals, do things with groups of people, and go outside. R1's Care Area Assessments (CAA) dated 11/15/17, for cognitive loss/dementia indicated	21435	Corrected	

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21435	Continued From page 15 R1 propelled own wheelchair around the care center, had a moderately impaired cognitive impairment, and was able to make simple daily decisions. R1's cognitive loss CAA indicated R1 had difficulty focusing attention, and was easily distracted. R1's CAA for psychosocial well-being indicated R1 did not answer questions regarding importance of participation in favorite activities, and had variable moods during activities. R1's CAA indicated R1 would stay and observe activities for approximately 45 minutes, or would watch game shows on the television. R1 spent time wandering in hallways, holding a doll, visiting with staff, watching tv and attending activities. 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.	21435		

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21435	Continued From page 16 -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 in exercise, tv, walking with resident/sitting with staff -on 4/1/18, in the afternoon R1 spent 360 minutes in a 1:1 visit, coffee group, and observing others -on 3/31/18, in the afternoon R1 spent 360 minutes in a 1:1 visit, coffee group, and observing others -on 3/30/18, in the evening, R1 spent 100 minutes reading/writing, tv/movies, with children, and a 1:1 visit -on 3/30/18, in the morning, R1 spent time watching tv/movies, coffee group, and holding a doll and sitting with staff. Further documentation indicated R1 participated in these activities one to two times daily for 60 minutes to 360 minutes each time. Documentation for the afternoon on 4/3/18, indicated R1 participated in coffee group and observing others for 180 minutes, and on the morning of 4/4/18, R1 participated in pet visits, and sitting with staff for 90 minutes. On 4/2/18, at 6:15 p.m. R1 was observed wandering in the hallway and into others' rooms. The outside door alarm sounded and she was removed from the area. At 6:25 p.m. R1 was observed in the day area on the unit, smiling and conversing with others. Staff took her to her room at that time. On 4/4/18, between 8:48 a.m. and 10:18 a.m. R1 was observed to eat breakfast, wander in the hallways on the unit, sit and look out the windows	21435		

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for over a half hour, then hold a doll and talk to the doll. An activity on the other unit at that time, included making ice cream.

On 4/4/18, at 10:06 a.m. nursing assistant (NA)-B stated R1 wandered, but has wandered less since moving to the new unit.

On 4/4/18, at 2:53 p.m. R1 was observed wandering in the hallways on the unit, and occasionally staff stopped to say hello, and continued on their way. R1 was holding the doll. In the common activity area, other residents were planting seeds. No pets were observed visiting with R1 during the day.

On 4/5/18, at 9:37 a.m. R1 was sitting quietly at the counter after eating her breakfast.

On 4/5/18, at 9:42 a.m. housekeeper (H)-A stated R1 has not had a bad day since moving the new unit. H-A stated R1 wandered less into others' rooms. H-A stated R1 liked her dolls and had three. H-A also stated R1 liked her stuffed cat, liked her nails done so activities will do her nails every so often, or they would do 1:1 visits with her. H-A stated R1 usually does not go to group activities because she wanders.

On 4/5/18, at 9:56 a.m. H-A brought R1 her stuffed cat and R1 talked to the cat, which was purring. R1 spent the morning on the unit, holding her cat and moving about the unit.

R17's History and Physical dated 12/19/17, indicated R17's diagnoses included a stroke, advanced Alzheimer's dementia, and depression. R17's History and Physical further addressed R17's dementia, and directed nursing to continue to do interventions to stimulate her, and

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21435	Continued From page 18 encourage her to participate as able, and noted that R17 had been watching the Price is Right with other residents. R17's quarterly MDS dated 12/21/17, indicated R17 had severely impaired cognitive skills for daily decision making, had symptoms of delirium, hallucinations, and physical and verbal behaviors 1-3 days during the assessment period. R17's MDS further indicated R17 required total assistance of staff with locomotion on the unit, and locomotion off the unit did not occur. R17's comprehensive MDS, in process during the survey, indicated R17 indicated it was very important for R17 to go outside when the weather was good, otherwise, activities listed were either not very important or not important at all to R17. R17's CAA dated 4/3/18, for cognitive loss/dementia indicated R17 had severely impaired cognitive skills for daily decision making abilities, had symptoms of inattention and had disorganized thinking. R17's CAA for psychosocial well-being referred to the mood CAA which indicated R17 had no signs or symptoms of depression. R17's CAAs did not address activity participation. R17's activity documentation indicated the following: -on 4/5/18, in the morning R17 participated in exercise, visitors, and pet visits for 90 minutes. -on 4/4/18, in the evening R17 participated in TV/movies and 1:1 visits for 30 minutes. -on 4/4/18, in the morning, R17 participated in tv/movies for 45 minutes. -on 4/3/18, in the later afternoon, R17 participated in tv/movies, 1:1 visits, coffee group, and the birds for 180 minutes. -on 4/3/18, in the early afternoon, R17	21435		

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participated in tv/movies, 1:1 visits coffee group, birds, observing others and "zzzzzz" (sleeping) for 180 minutes.
-on 4/2/18, in the evening R17 participated in tv/movies, 1:1 visits, coffee group, and observing others for 120 minutes.
-on 4/2/18, in the morning R17 participated in pet visits and coffee group for 45 minutes.
-on 4/1/18, in the afternoon R17 participated in tv/movies, 1:1 visits, observing others and "zzzzz" (sleeping) for 360 minutes.
Further activity documentation indicated R17 participated in these activities 1 to 2 times daily, for 30 to 360 minutes. Several entries included sleeping time, sitting in front of the TV, and observing others, without interaction as activities.

A review of R17's activity participation and the activity calendar for March 2018, indicated R17 was not taken to group activities, including BINGO on 3/17 and 3/31. The same was true in February 2018.

On 4/4/18, at 8:47 a.m. R17 was sitting quietly in the dining room and was assisted by staff to eat breakfast.

On 4/4/18, at 9:00 a.m. R17 was moved from the table to sit in front of the TV in the day area.

On 4/4/18, at 9:42 a.m. R17 was brought to her room, and at 10:01 a.m. she was brought down to the end of the hall to sit in the sunlight.

On 4/4/18, at 2:52 p.m. R17 was lying quietly in bed. There was an activity in the day area with residents planting seeds.

On 4/5/18, at 9:35 a.m. R17 was sitting in front of the TV on the unit, with her eyes closed, following

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breakfast. At 9:38 a.m. AD-A asked if she wanted to go out to sit in front of the birds with her friends, and R17 said she did. An NA first took R17 to her room for cares.

On 4/5/18, at 9:51 a.m. R17 was returned to the unit day area and placed in front of the TV, with closed eyes. R17 sat there alone, without other residents or staff in the area. At 9:54 a.m. activity director (AD)-A returned to the unit and left the unit without taking R17 to activities.

On 4/4/18, at 9:58 a.m. NA-B stated R17 displayed physical behaviors toward staff during cares, but R17's behaviors have decreased since moving to the new unit. NA-B stated they place R17 in the sun for 25 minutes daily. NA-B stated activities staff tend not to take R17, R1, and those residents who are unable to participate fully in activities, to group activities. NA-B stated the NAs have been trying to push their attendance in activities.

On 4/5/18, at 11:28 a.m. the director of nursing (DON) stated dementia activities were lacking, and verified there were no pet visits on the units on 4/4/18, as documented in R1's activity documentation. The DON stated activities for residents with dementia often included sitting in front of the birds and other such activities, which were not engaging them. The DON stated they were trying to revamp activities. The DON stated engaging R1 in activities would decrease her wandering into other rooms. The DON stated they do more baking and other activities in the evenings, and the nursing assistants on the unit are very good with R1.

On 4/5/18, at 11:44 a.m. activity director (AD)-A stated if residents were unable to participate in

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activities, he would take them to the group, the bird aviary, outside, do their nails, etc. AD-A stated bringing to the group activities is beneficial and verified they had not done 1:1 activities with R1 during observations. AD-A stated R1 usually comes to BINGO, and families sit with her. AD-A stated pet visits included everything, including the bird aviary. AD-A verified pets did not visit as documented. AD-A stated they make sure residents with dementia are seen by activities weekly. AD-A stated staff participate in dementia training and are scheduled to attend the training. AD-A stated R1 will hold a doll or her cat, and likes to sit with the staff when they are charting. AD-A stated R17 was brought to a quiet place, and they place her in the sun because she did that at home. AD-A stated they do not bring R17 to church, on bus trips or music programs, as music is noise to her. AD-A stated they do nails and lotions weekly for R1 and R17. AD-A stated 1:1 activities are not scheduled for them.

The facility was unable to provide a policy on activities for residents with dementia.

R16's Face Sheet dated 3/19/18, indicated R16's diagnoses included altered mental status, major depressive disorder, and unspecified psychosis.

R16's History and Physical dated 1/26/18, indicated R16 resisted much of therapy, most of the time, and refused medication; resident is on very little.

R16's care plan reviewed 2/27/18, indicated R16 was at risk for impaired psychosocial wellbeing related to delusions that staff wanted to harm resident. Interventions included R16's preference to go to bed and get up when resident asked, establish a trusting relationship, and provide

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reassurance and comfort. The care plan also indicated a risk for impaired social interaction as R16 wanted to remain in a certain place most of the day, or in a recliner. The care plan noted R16 often yelled out when seen on a 1:1 basis. Interventions included providing a picture of R16 and spouse at meal table as this was where she preferred to sit throughout the day, offer coffee while she's sitting in the dining area, verbal reminders of activity times, bringing resident to activities using wheelchair, table games, encouragement to attend music programs, and active games. R16's goal was specified that she will observe the picture of spouse and self, three times daily (meals), and resident will accept 1:1 visits three times weekly.

R16's activity documentation records for the month of February 5, 2018, through April 4, 2018, consistently included combined recording of very general activities. Daily recordings for those 59 days included combined activities participated in as TV or movies, 1:1 visit, coffee group, observing others, and sleeping for lengths of time varying from 20 minutes to 360 minutes. All activities recorded 2/5/18, through 4/4/18, included 1:1 visit recorded 61 times, coffee group recorded 53 times (often more than once per day), observing others and/or sleeping recorded as an activity 38 times, TV or movies recorded 49 times, observing R16's picture recorded twice (though picture observed to be in front of R16 for each meals observed during survey), took R16 to x-ray recorded as an activity once, luncheon recorded once, party recorded once, children recorded once, pet visits recorded once, visitors recorded once, beauty shop recorded once, talked about dancing recorded once, read R16's mail to resident recorded once, and music activity recorded once.

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21435	Continued From page 23 April 3, 2018, activity documentation record for R16 at 1:08 p.m. included Activities Participated in today - TV or Movies, Coffee Group and Other Activities Not Listed of Sleeping for Amount of Time in Activity - 180 minutes. Activity documentation record dated April 3, 2018, at 3:27 p.m. listed Activities Participated in today as TV or Movies and Sleeping for 180 minutes. Reviewer noted that 180 minutes had not elapsed between activity staff recordings. On 4/4/18, at 2:02 p.m. nursing assistant (NA)-E was interviewed. When asked if R16 had experienced changes in activity levels, NA-E stated R16 used to sit and watch activities but never participated. NA-E stated now R16 sits by herself, and doesn't usually eat at the same time the other residents eat. On 4/4/18, at 2:04 p.m. NA-D stated she recently started working with R16, and had noted that R16 slept more during the day, especially if she had a rough night. On 4/4/18, at 2:04 p.m. NA-C stated that when she visits with R16 she didn't get as much response currently as she did previously. NA-C used to dance with R16 by taking her hands while she was in a wheelchair. NA-C stated she had joked with R16 and had fun, but R16 doesn't do that anymore. NA-C noted that R16 slept more now as part of the decline of aging. The facility's undated Alzheimer's Disease and Dementia training materials provided did not include information on meaningful activities for residents with dementia.	21435		

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21435	Continued From page 24 SUGGESTED METHOD OF CORRECTION: The Director of Nursing and activity director or designee could develop, review, and/or revise policies and procedures to ensure meaningful activities for residents with dementia are provided. The Director of Nursing and activity director or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing and activity director or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director	21530		4/30/18

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21530	Continued From page 25 of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure pharmacy recommendations were reviewed by the director of nursing (DON) and medical director (MD) for 5 of 5 residents (R9, R27, R6, R3, and R16). In addition, the facility failed to ensure pharmacist recommendations were responded to timely for 1 of 5 residents (R3) reviewed for unnecessary medications. Findings include: R9's Face Sheet indicated R9's diagnoses included acute kidney failure, dementia, hypothyroidism, and atherosclerotic heart disease. R9's quarterly Minimum Data Set (MDS) dated	21530	Corrected	

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21530	Continued From page 26 1/17/18, indicated R9 was cognitively intact, had mood symptoms, hallucinations, anxiety, depression and pain. R9's MDS further indicated R9 received antipsychotic, antianxiety, antidepressant, anticoagulant, diuretic, and opioid medications during the assessment period. R9's Physician Orders included orders for medications that included dementia medications, pain medications including opioids, antipsychotic medications, anticoagulant medications, diuretic medications, thyroid medications, blood pressure medications, antianxiety medications, antidepressant medications, respiratory medications, and sleep aid medications. R9's monthly consultant pharmacist reviews included several recommentations requiring review and follow up by the physician. R9's pharmacy consultant recommendations were reviewed and followed up on by R9's physician, but lacked review by the DON and the medical director. R27's Face Sheet indicated R27's diagnoses included acute kidney failure, anemia, pain, wheezing, and terminal atrophy of the kidney. R27's annual MDS dated 1/14/18, indicated R27 was cognitively intact, had mild symptoms of depression, depression, pain affecting sleep and daily activities, and received an antidepressant and diuretic medication. R27's Physician Orders for medications included antidepressant medications, pain medications, blood pressure medications, and diuretic medications. R27's monthly consultant pharmacist reviews	21530		

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included several recommentations requiring review and follow up by the physician. R27's pharmacy consultant recommendations were reviewed and followed up on by R27's physician, but lacked review by the DON and the medical director.

R6's quarterly MDS dated 3/13/18, identified diagnoses of high blood pressure, high cholesterol, and depression. Medications included antipsychotic medications, antidepressant medications, and diuretic medications.

R6's monthly consultant pharmacist reviews included recommendations requiring review and follow up by the physician. R6's pharmacy consultant recommendations were reviewed and followed up on by R6's physician; however, lacked review from the DON and the MD.

R3's quarterly MDS dated 1/6/18, identified diagnoses of high blood pressure and high cholesterol.

R3's Physician Order Sheet dated 3/27/18, identified orders for blood pressure medications including Norvasc, Apresoline, Zestril, Lopressor. The Physician Order Sheet identified an order for Lipitor for high cholesterol.

R3's pharmacy medication reviews identified the following recommendations:

- 11/24/17, the consulting pharmacist recommended the physician to clarify the frequency of R3's blood pressure checks.

- 12/7/17, the consulting pharmacist recommended checking R3's fasting lipid panel

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21530	Continued From page 28 (lab to check cholesterol levels) to ensure appropriate therapy. The last fasting lipid panel was completed October of 2016. The physician did not address the 11/24/17, and the 12/7/17, consulting pharmacist recommendations in writing, nor were the recommendations reviewed by the DON or MD. On 4/5/18, at 1:14 p.m. registered nurse (RN)-D stated it had been a year and half since R3 had a lipid panel completed. The physician failed to address ordering the lipid panel or justification for not ordering it. In addition, the physician failed to address how often R3's blood pressure should be checked. R3 did not have a specific order for frequency of blood pressure checks and received them weekly and as needed. The current process for pharmacy consult recommendations included the pharmacist completing the recommendations in the medical record. They were then printed and given to her self or a designee to place in the physicians rounding forms to address. There was not a current process to ensure the physician follows up on the recommendations. At 1:24 p.m. the director of nursing (DON) stated he did not review the pharmacy consults recommendations and the MD did not review them either. The DON stated it was a challenge to get the physicians to address all the identified recommendations. There was not a current process to ensure the physician addressed the recommendations. At 2:58 p.m. the consulting pharmacist (CP) stated she sends the irregularities and recommendations to the DON and MD. If she needed an immediate response from a physician, she would go to the physician herself. The CP	21530		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 29 stated she felt she gets a timely response on her recommendations, and the physician's approve 90 percent of them. The facility policy Care Center Medication Review dated 2017, directed when the pharmacist discovered an irregularity it would be documented in the residents medical record and printed and forwarded to the physician for review. All irregularities and recommendations would be added to a spread sheet in the pharmacy, which would be used for follow up. The recommendations would be reviewed quarterly for completion and if appropriate re-submitted to the physician. A report would be generated at the end of the month. The report would include all irregularities and recommendations and would be sent to the director of nursing and medical staff director for review. R16's Face Sheet dated 3/19/18, identified diagnoses that included altered mental status, edema, essential hypertension, hypokalemia (blood potassium levels are too low), major depressive disorder, and unspecified psychosis. R16's consultant pharmacist monthly review note 9/15/17, included: Medication review for August: Recommend checking potassium level because of diuretic therapy for edema. Last level was in February 2017. R16's consultant pharmacist monthly review dated 10/16/17, included: Medication review for September: Mirtazapine due for a gradual dose reduction or documentation why it is not appropriate. Recommend rechecking potassium level due to diuretic use; last level is from February 2017.	21530		

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	00586	A. BUILDING: _____ B. WING _____	04/05/2018

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21530	Continued From page 30 R16's consultant pharmacist monthly review note 11/10/17, included: Medication review for October: Recommend rechecking a potassium level as furosemide is expected to lower it. Last level is from February 2017. R16's MD notes dated 10/31/17, 11/09/17, and 12/22/17, lacked an order to check for a potassium level. On 4/5/18, at 2:25 p.m. the DON stated when the pharmacist puts in a recommendation, the recommendation gets printed out,and goes to nursing. During the monthly resident MD rounds, the physician sees the recommendation, and he would expect the MD act upon it. The DON stated that the facility lacked a process for the DON and other nurses to see the consultant pharmacist recommendations, and see any action the physician took on the recommendations. The DON stated the MD doing the monthly rounding should respond to the consultant pharmacist's recommendations within a week or even at the next monthly review. The DON stated they do not have a system in place to make sure the physician responds to the consultant pharmacist's recommendations. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure pharmacist recommendations are reviewed by the director of nursing and medical director review pharmacist recommendations and responded to the resident's physician in a timely manner. The Director of Nursing or designee could educate all appropriate staff and medical director on the policies and procedures.	21530		

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21530	Continued From page 31 The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the	21545		5/15/18

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21545	Continued From page 32 resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were not crushed without a physician's order for 2 of 9 residents (R11, R19) observed for medication administration. This resulted in a medication error rate of 14%. Findings include: R11's History and Physical dated 7/10/17, indicated R11's diagnoses included chronic pain, macular degeneration and esophageal strictures. R11's signed Physician Orders dated 2/23/18, included orders for: Occuvite with Lutein (vitamin to support eye health) one tab po (by mouth) twice daily, Ultram (pain medication) 50 milligrams (mg) po three times daily, Aleve (nonsteroidal anti-inflammatory) 220 mg po twice daily. R11's orders lack directives to crush medications. On 4/2/18, at 5:37 p.m. during observation of	21545	Corrected	

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21545	Continued From page 33	21545		

medication pass, registered nurse (RN)-A crushed R11's naproxen sodium (Aleve), Occuvite, and tramadol (Ultram) medications prior to administration of these medications. RN-A administered the crushed medication in applesauce to R11. RN-A stated R11 has medications crushed, but did not know if R11 had an order for crushing medications. RN-A stated the medications were okay to crush as far as she knew.

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. during observation of medication pass, RN-B stated that for the most part, they give R11's 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 3 spoonfuls. RN-B proceeded to administer R11 tramadol whole in applesauce, which he took without difficulty.

R19's History and Physical dated 6/28/17, indicated R19's diagnoses included Alzheimer's and osteopenia (bone loss) with a history of related fractures.

R19's signed Physician Orders dated 3/28/18, included orders for Tylenol (acetaminophen) 650 mg po four times daily for arthritis. R19's physician orders lacked orders to crush medications.

On 4/3/18, at 11:54 a.m. RN-B crushed R19's acetaminophen, and administered it in applesauce to R19. RN-B incorrectly stated R19 had an order to crush medications.

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21545	Continued From page 34 On 4/4/18, at 11:00 a.m. director of nursing (DON) verified medications were not to be crushed without a physician's orders. The facility policy Administration of Medication in Long Term Care dated 4/13/17, directed nursing to crush pills when necessary according to physician orders, manufacturer's information, pharmacist, and drug reference. The policy and procedure further indicated medications may be crushed together unless contraindicated by physician order, manufacturers information or accepted principles and standards. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure medications are not crushed and mixed together without a review and order by the physician. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		