DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 8, 2025

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

RE: CCN: 245392
Cycle Start Date: April 10, 2025

Dear Administrator:

On May 7, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 8, 2025

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

Re: Reinspection Results
Event ID: 3VRH12

Dear Administrator:

On May 7, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 10, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 23, 2025

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

RE: CCN: 245392
Cycle Start Date: April 10, 2025

Dear Administrator:

On April 10, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Cell: 651-279-5375 Office: 218-302-6186

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by July 10, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 10, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

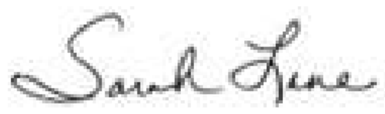
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process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

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
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P.O. Box 64900
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING _____ B. WING _____	C 04/10/2025

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 On 4/7/25 to 4/10/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/7/25 to 4/10/25, a standard recertification 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, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		4/23/25

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

Electronically Signed | 04/25/2025

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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F 655	Continued From page 1 §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be	F 655		

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F 655	Continued From page 2 administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a baseline care plan to ensure immediate resident needs were identified and addressed for 1 of 5 residents (224) reviewed for comprehensive care planning and new admissions. Findings include: R224's face sheet indicated an admission date of 4/2/25, with a diagnosis of cerebral vascular accident. R224's paper baseline care plan indicated a completion date of 4/7/25. During an interview on 4/10/25 at 10:39 a.m., registered nurse (RN)-A stated the initial care plan was filled out in paper form and started at the time of admission. It took about 5 days for the initial care plan to be completed. During an interview on 4/10/25 at 11:48 a.m., the director of nursing stated the care plan needed to be done within 24-48hrs after admission. Facility policy Charting last reviewed 11/18/24, indicated a baseline care plan would be developed within 24hours of admission addressing pertinent problems/needs of the resident	F 655	DON provided immediate education on 4/11/25 to the Nurse Manager and MDS/RN Educator on the "Charting" policy which includes the expectation that the Baseline Care Plan for all new resident admissions will be completed within 24 hours of admission. Ongoing monitoring: The DON created a QAPI on 4/23/25 in which the DON will audit all new admissions within 24 hours to ensure that the Baseline Care Plan is completed. Audits will be performed x 6 months and will be reported at the QAPI committee.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices	F 689		5/1/25

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F 689	Continued From page 3 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess each fall to ensure interventions were followed; and failed to ensure fall interventions were care planned timely and implemented to prevent falls for 1 of 1 resident (R5) reviewed for falls. Findings include: R5's annual Minimum Data Set (MDS) dated 2/10/25, identified R5 had moderate cognitive impairment and diagnoses that included dementia, depression, osteoporosis and neurogenic bladder (as medical condition that causes bladder control issues). R5 had a history of fall without injury in the last 90 days. R5 had a bed alarm and chair alarm in place to monitor R5's movement and alerted staff when movement was detected. R5's care plan started 9/28/24, identified R5 was at risk for fall as evidenced by a history of falls, wandering, dizziness, impaired balance, impaired cognition and a history of self-transferring. Interventions included a post fall root cause analysis, bed sensor pad, fall risk assessment and vital signs. The care plan lacked any other	F 689	Immediately on 4/11/25- the Nurse Manager was re-educated on the Falls Program policy which includes the expectation to perform a full review of the post fall incident and post fall assessment/RCA. The Nurse Manager is to ensure that all fall program steps have been followed including identification of potential/real contributing factors including the nurse reviewing toileting plans (as applicable) as would have been the expectation post fall for R5. The expectation of the investigation and review post fall is to ensure that all care plan items were provided to the resident per the care plan, specific to that resident. This information must be documented on by the nurse immediately post fall during the RCA assessment. The nurse manager must follow up with the individual nurse if the post fall/RCA in the resident chart does not include the full review of individualized care plan services that are provided. This will ensure that the post fall/RCA has been performed correctly. Additionally nursing must review that all current fall interventions for the resident	

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F 689	Continued From page 4 interventions to attempt to protect the resident from falls. R5'S Post Fall Documentation (PFD) form last updated 12/12/24, indicated on 3/29/25 at 10:20 p.m., R5 was found on the floor by the bed after trying to transfer from the wheelchair to the bed. There were no behaviors documented as contributing to the fall other than resident had self-transferred. Nursing assessment indicated no injury occurred. Diagnoses listed as contributing factors included dementia, hypertension, anemia, and neurogenic bladder. The PFD lacked documentation related to last toileted or self-catheterized. Fall precautions in place in place included bed and chair sensors. The form indicated precautions such as floor mats, "anti tippers", gripper socks or call signage were in place. The form indicated a post fall root cause analysis was competed, the resident was a high fall risk, and no immediate interventions were implemented. The conclusion indicated current interventions appropriate due to dementia and unable to follow recommendations. The PFD lacked documented information related to if appropriate footwear was on, if the call light was available, and when the resident had last been seen. R5's Post Fall & Root Cause Analysis (PFRCA) dated 3/29/25 at 10:32 p.m. indicated the same information as the Post Fall Documentation form. Interventions of frequent checks was also added. The PFRCA lacked any other information related to a comprehensive assessment/investigation into the fall was performed or what was reviewed as part of the PFRCA. R5'S Fall Worksheet dated 3/29/25, indicated no	F 689	are in place and must implement new interventions, specific to the resident who had the fall to ensure the risk for another fall is decreased. The Fall Program policy was updated on 4/25/25 to include immediate interventions that nurses must review to determine if the resident who has fallen needs implemented immediately, what safety measures are in place for the resident currently, if those were followed by staff and resident, if care plan items such as toileting plans/safety checks have been provided by staff and if they are in compliance as care planned. The post fall assessment/RCA must be completed fully as per the Falls Program policy. Nursing staff will be re-educated to the Fall Program policy by May 1st, 2025. R5's fall interventions were reviewed and found current on 4/11/25. All other residents who have had falls within the last 30 days were reviewed with all fall interventions found current as of 4/23/25. Ongoing monitoring: The DON created a QAPI on 4/23/25 to ensure that ongoing monitoring is completed as per (the Fall Program policy) with all falls. This QAPI also includes the DON reviewing/monitoring the post fall review documentation by the Nurse Manager, in collaboration with the IDT team to ensure documentation by the nurses is complete, additional falls	

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F 689	Continued From page 5 new interventions were added to R5's care to attempt to prevent falls. During an interview on 4/8/25 at 9:45 a.m., nurse assistant (NA)-A stated residents would be put on frequent checks after fall for an undisclosed amount of time to keep a close observation of them to prevent further falls. Frequent falls meant they would be observed every 30 minutes and then documented on a paper form where we wrote down when they were checked, who did the check and where they were located at the time of the check. NA-A stated R5 had not been on frequent checks for several months. During an interview on 4/8/25 at 10:03 a.m., licensed practical nurse (LPN)-A stated when a resident fell there was a fall assessment that is filled out and then given to the director of nursing (DON). I do not know what happens after that point. LPN-A also stated residents after falls would be placed on frequent checks. Frequent checks could be anywhere from every hour to every fifteen minutes. Documentation of frequent checks were done on a paper form and entered in the computer. During an interview on 4/8/25 at 10:39 a.m., registered nurse (RN)-A stated when a fall occurred the fall paperwork was given to the DON and then the DON would give RN-A the paperwork to review. Part of the review process would be to talk with staff about the incident, look at the resident's medical record, and evaluate causes for the fall. A root cause analysis would be performed by myself to decide the cause of the fall and what if any changes need to occur. RN-A reviewed R5's fall paperwork from 12/12/24 and stated a lot of information was missing	F 689	measures are put in place as pertain and are documented, that IDT's input is noted per the Falls Program policy and the care plan is updated with any changes in interventions post fall. DON will audit all falls documentation and IDT follow up twice weekly x 4 weeks, then weekly x 3 weeks, then weekly x 2 weeks.	

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F 689	Continued From page 6 related to the fall and what occurred at the time of the fall. Interviews with the staff to investigate the fall did not occur so there were unanswered questions related to the fall and why it occurred. RN-A knew R5 and knew she would just keep getting up on her own, so I just copied the information from the nursing documentation onto my review and started frequent checks. RN-A was unable to show the frequent check documentation and stated frequent checks were never started by the staff. During an interview on 4/8/25 at 11:10 a.m., the DON stated a complete investigation and root cause analysis should be performed to evaluate why a fall occurred and how to attempt to prevent further falls. Interventions should be care planed and started based on recommendations found through the investigation process. The facility policy Falls Program-Care Center last reviewed 4/11/25, indicated the licensed nurse would perform a post fall huddle/root cause analysis to determine any potential contributing factors to a fall. Post fall interventions would be put into place based on the RCA. The nurse manager or DON would then review the fall with reenactment if there were questions or concerns related to the fall.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 758		5/1/25

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F 758	Continued From page 7 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or	F 758		

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	245392	A. BUILDING _____ B. WING _____	C 04/10/2025

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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 758	Continued From page 8 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide appropriate side effect monitoring with antipsychotic medication consumption related to residents who did not have an Abnormal Involuntary Movement Scale (AIMS) for 1 of 5 residents (R14) reviewed for unnecessary medication use. Findings include: R14's quarterly Minimum Data Set (MDS) dated 1/27/25, indicated R14 had intact cognition. Diagnoses included psychotic disorder and post-traumatic stress disorder. R14's active order list undated, indicated R14 received Zyprexa, an antipsychotic medication that can cause involuntary muscles movements of the body, 5 milligrams (mg) by mouth in the evening. R14's medical record lacked documentation an AIMS assessment was performed prior to the start of the medication or since the medication was started. During an interview on 4/9/25 at 12:45 p.m., registered nurse (RN)-B stated when a resident was put on an antipsychotic medication an order was entered to monitor for side effects such as nausea, vomiting, hallucinations and TD. The Nursing staff had to check each shift the side effects were monitored. We did not actually do any kind of AIMS assessment before an antipsychotic medication was started as a	F 758	Pharmacist and DON met 4/23/25 to update the Psychotropic Medication policy to include that a baseline AIMS assessment for those residents taking any antipsychotic is performed upon admission, quarterly, and with addition of an antipsychotic for a resident by the Nurse Manager or DON. The policy will be completed by May 1, 2025. All nursing staff will be educated on this policy by May 1, 2025. Nursing staff continue to monitor for all signs/symptoms of TD on any resident who is prescribed an Antipsychotic medication every shift per the Antipsychotic assessment in Maas (electronic medical record). R14 will have the baseline AIMS assessment completed by 5/1/25 by the DON or Nurse Manager. Current residents: All residents currently on an Antipsychotic will have the AIMS Assessment performed on them by the DON or Nurse Manager by May 1st, 2025. Then ongoing AIMS assessments quarterly by the DON or Nurse Manager. Ongoing Monitoring: The DON created a QAPI on 4/23/25 to ensure all residents receiving an antipsychotic medication will have a	

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F 758	Continued From page 9 baseline or while on the medication. During an interview on 4/10/25 at 9:48 a.m., the consultant pharmacist (CP) stated they do not look for AIMS assessments when doing the chart reviews because of the monitoring interventions are in place and documented on. The CP stated the facility probably should do a baseline AIMS prior to start of a new antipsychotic so there is a documented baseline and then would then know when a change occurred. During an interview on 4/10/25 at 11:48 a.m., the director of Nursing stated AIMS assessments specifically were not performed as part of assessments, but the monitoring interventions did list TD effects that were monitored and documented on during each shift. Facility policy Psychotropic Medications last revised 4/5/23 indicated side effect monitoring would be entered into the care plan and reviewed quarterly. Refer to state and federal regulations for long term care for a list of psychotropic dose specifics and adverse consequences of psychotropic medications	F 758	baseline AIMS performed upon admission, then quarterly thereafter. The DON will also audit to ensure that licensed nursing is completing the Antipsychotic Symptoms Assessment on those residents shiftly as required. Audits as noted in this QAPI will be 5x/week x 3 weeks; then 3x/week x 2 weeks, then weekly x 6 weeks.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 23, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: 3VRH11

Dear Administrator:

The above facility was surveyed on April 7, 2025 through April 10, 2025 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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:

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Cell: 651-279-5375 Office: 218-302-6186

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 feel free to call me with any questions.

Sincerely,

Sarah Lane

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

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 _____	C 04/10/2025

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COOK COMMUNITY HOSPITAL C&NC	10 SOUTHEAST FIFTH STREET COOK, MN 55723

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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: On 4/7/25 to 4/10/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota 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. 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	2 000		

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, 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 and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide appropriate side effect monitoring with antipsychotic medication consumption related to residents who did not have an Abnormal Involuntary Movement Scale	21535	Pharmacist and DON met 4/23/25 to update the Psychotropic Medication policy to include that a baseline AIMS assessment for those residents taking any antipsychotic is performed upon	5/1/25

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21535	Continued From page 3 (AIMS) for 1 of 5 residents (R14) reviewed for unnecessary medication use. Findings include: R14's quarterly Minimum Data Set (MDS) dated 1/27/25, indicated R14 had intact cognition. Diagnoses included psychotic disorder and post-traumatic stress disorder. R14's active order list undated, indicated R14 received Zyprexa, an antipsychotic medication that can cause involuntary muscles movements of the body, 5 milligrams (mg) by mouth in the evening. R14's medical record lacked documentation an AIMS assessment was performed prior to the start of the medication or since the medication was started. During an interview on 4/9/25 at 12:45 p.m., registered nurse (RN)-B stated when a resident was put on an antipsychotic medication an order was entered to monitor for side effects such as nausea, vomiting, hallucinations and TD. The Nursing staff had to check each shift the side effects were monitored. We did not actually do any kind of AIMS assessment before an antipsychotic medication was started as a baseline or while on the medication. During an interview on 4/10/25 at 9:48 a.m., the consultant pharmacist (CP) stated they do not look for AIMS assessments when doing the chart reviews because of the monitoring interventions are in place and documented on. The CP stated the facility probably should do a baseline AIMS prior to start of a new antipsychotic so there is a documented baseline and then would then know	21535	admission, quarterly, and with addition of an antipsychotic for a resident by the Nurse Manager or DON. The policy will be completed by May 1, 2025. All nursing staff will be educated on this policy by May 1, 2025. Nursing staff continue to monitor for all signs/symptoms of TD on any resident who is prescribed an Antipsychotic medication every shift per the Antipsychotic assessment in Maas (electronic medical record). R14 will have the baseline AIMS assessment completed by 5/1/25 by the DON or Nurse Manager. Current residents: All residents currently on an Antipsychotic will have the AIMS Assessment performed on them by the DON or Nurse Manager by May 1st, 2025. Then ongoing AIMS assessments quarterly by the DON or Nurse Manager. Ongoing Monitoring: The DON created a QAPI on 4/23/25 to ensure all residents receiving an antipsychotic medication will have a baseline AIMS performed upon admission, then quarterly thereafter. The DON will also audit to ensure that licensed nursing is completing the Antipsychotic Symptoms Assessment on those residents shiftly as required. Audits as noted in this QAPI will be 5x/week x 3 weeks; then 3x/week x 2 weeks, then weekly x 6 weeks.	

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21535	Continued From page 4 when a change occurred. During an interview on 4/10/25 at 11:48 a.m., the director of Nursing stated AIMS assessments specifically were not performed as part of assessments, but the monitoring interventions did list TD effects that were monitored and documented on during each shift. Facility policy Psychotropic Medications last revised 4/5/23 indicated side effect monitoring would be entered into the care plan and reviewed quarterly. Refer to state and federal regulations for long term care for a list of psychotropic dose specifics and adverse consequences of psychotropic medications. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and the consulting pharmacist should develop and/or revise policies to monitor medications for adequate indications for use to treat a specific condition(s) as diagnosed and documented in the clinical record to ensure each resident's entire drug medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being and be consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review articles that are published in medical and/or pharmacy journals. The director of nursing (DON) or designee and the consulting pharmacist should educate physicians and staff on the importance of ensuring medication ordered is appropriate for each resident's use. Audits should be developed to monitor medications for adequate indications for use and appropriate timeframe's for a specific and	21535		

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21535	Continued From page 5 measurable amount of time. The DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: 21 DAYS	21535		

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	245392	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/08/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/08/2025. At the time of this survey, Cook Community Hospital C & NC was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/25/2025

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 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Cook Hospital C & NC is a 1-story building with a partial basement. The original building was constructed in 1960 with additions in 1966, 2000, 2005, and 2017. The original 1960 building and the 1966, 2000, and 2005 additions are all Type II (111) construction. The 2017 addition was determined to be of Type II(000) construction. The original building and all of the additions including the 2017 which had plans approved prior to July 5, 2016 were considered existing building for inspection purposes and the facility	K 000		

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K 000	Continued From page 2 was inspected as 1 building. The facility has 2 smoke compartments and is separated from the hospital by a 2 hour fire rated wall. The building is fully fire sprinkler protected.. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 28 beds and had a census of 23 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	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 a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety	K 712	Fire drills to be held at expected and unexpected times at least quarterly on each shift will be completed by the	4/25/25

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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
K 712	Continued From page 3 Code sections 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/08/2025 between 11:00 AM and 1:30 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a fire drill had been completed during the First Shift during the Third quarter of 2024. An interview with the Plant Operations Manager verified this deficient finding at the time of discovery.	K 712	maintenance staff and/or maintenance supervisor. The maintenance supervisor created a calendar reminder to ensure prompting to complete the fire drill each shift per quarter. Ongoing monitoring: The Maintenance Supervisor started a QAPI on 9/4/24 to ensure fire drills were completed every shift each quarter by the maintenance staff. The Maintenance Supervisor will ensure that all drills are completed on time each quarter. Since starting this QAPI on 9/4/24, all fire drills have been completed each quarter. This QAPI will continue for the remainder of 2025.	