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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 616J

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 **03/25/2016** (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 :
Kathie Killoran, HFE NE II — 03/25/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 05/03/2016 (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
04/04/2016
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245392
April 8, 2016

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

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 March 25, 2016 the above facility is certified for or recommended 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 8, 2016

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

RE: Project Number S5392026

Dear Ms. Debevec:

On March 2, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 19, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On March 25, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 5, 2016 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 February 19, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 25, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 19, 2016, effective March 25, 2016 and therefore remedies outlined in our letter to you dated March 2, 2016, 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245392 Y1	A. Building B. Wing Y2	3/25/2016 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0164	Correction	ID Prefix F0282	Correction	ID Prefix F0314	Correction
Reg. # 483.10(e), 483.75(l)(4)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(c)	Completed
LSC	03/23/2016	LSC	03/17/2016	LSC	03/17/2016
ID Prefix F0315	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.25(d)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/17/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	CC/KJ	04/08/2016	27200	03/25/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/19/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245392 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	4/5/2016 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0025	02/29/2016	LSC K0029	02/29/2016	LSC K0050	03/21/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0052	03/21/2016	LSC K0054	03/25/2016	LSC K0062	03/03/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0072	03/14/2016	LSC K0075	03/11/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	TL/KJ	04/08/2016	27200	04/05/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/17/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 3, 2016

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

Re: Reinspection Results - Project Number S5392026

Dear Ms. Debevec:

On March 25, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 19, 2016, with orders received by you on March 9, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00586 Y1	A. Building B. Wing Y2	3/25/2016 Y3

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	20565	Correction	ID Prefix	20905	Correction	ID Prefix	20910	Correction
Reg. #	MN Rule 4658.0405 Subp. 3	Completed	Reg. #	MN Rule 4658.0525 Subp. 4	Completed	Reg. #	MN Rule 4658.0525 Subp. 5 A.B	Completed
LSC		03/17/2016	LSC		03/17/2016	LSC		03/17/2016
ID Prefix	21855	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	MN St. Statute 144.651 Subd. 15	Completed	Reg. #		Completed	Reg. #		Completed
LSC		03/23/2016	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	CC/mm	05/03/2016	27200	03/25/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/19/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 616J

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: **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 **02/19/2016** (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:
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 :
Kathie Killoran, HFE NEII 03/11/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 04/01/2016 (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
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 2, 2016

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

RE: Project Number S5392026

Dear Ms. Debevec:

On February 19, 2016, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

Informal Dispute Resolution - 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 a "F" tag), i.e., the plan of correction should be directed to:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: chris.campbell@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 March 30, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a 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:

- 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 May 19, 2016 (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 August 19, 2016 (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 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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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 _____	02/19/2016

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 000	INITIAL COMMENTS 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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164		3/23/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/08/2016

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 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure privacy of personal status and care information for 2 of 2 residents (R28, R16) who were observed to have personal care completed and medical information discussed in public areas. Findings include: R28's quarterly Minimum Data Set (MDS) assessment dated 2//8/16, indicated R28 had a severe cognitive impairment, adequate hearing, was nonverbal, was able to understand others, and was usually understood. R28's physician visit notes dated 2/17/16, indicated R28's diagnoses included aphasia (inability to speak or verbalize clearly) and constipation. R28's care plan initiated 8/17/15, indicated R28 had an impairment of bowel elimination and the goal was to have bowel movements every 1-3 days. R28's care plan further indicated R28 had impaired communication due to an impaired ability to speak and a cognitive deficit with the inability to make choices and decisions. R28's physician orders dated 2/17/16, included	F 164	F164: DON immediately re-educated staff verbally on 2/19/16 as it is the policy of the Cook Hospital and Care Center to follow our Privacy and Confidentiality policy. Mandatory retraining meeting for all care center staff to be held on 3-16-16 and 3-17-16. Privacy/Confidentiality of records and dignity will be reviewed following our facility policy titled Privacy and Confidentiality (dated 6/27/14). All new employees will be oriented to said policy during their orientation. The Lab Director immediately re-educated the lab personnel verbally on 2-17-16. A new policy titled, "Care Center Resident Privacy-Laboratory" dated (3/2016) was developed indicating that all residents will be taken to a private area for any lab collections. All lab personnel will be educated as indicated by signing off on the new policy by March 11, 2016. All new labatory employees will be trained during their orientation. * SEE POLICY ATTACHED A QAPI was immediately initiated to	

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F 164	Continued From page 2 Docusate/Senna 50/8.6 milligrams (mg) twice daily and Bisacodyl 10 mg daily as needed for constipation. During an observation on 2/18/16, at 8:37 a.m. registered nurse (RN)-C loudly asked R28 if he would take pills to help him go to the bathroom. R28 was leaving the dining room after breakfast and there were 13 other residents and 6 other staff present in the dining room. R28 declined the medication. RN-C loudly stated that he had not had a bowel movement for 5 days and explained that they were the little round pills to help him go to the bathroom. RN-C stated again, that it had been 5 days and asked why he did not want to take them. R28 continued to decline to take the medication, and left the dining room. During an interview on 2/18/16, at 12:44 p.m. RN-C verified she had asked R28 about taking his bowel medications while in the dining room. RN-C verified she did ask R28 about his medications, and stated she could have asked him in his room. RN-C verified it was private information. During an interview on 2/18/16, at 1:32 p.m., R28 confirmed being asked about his bowel medications in the dining room, and nonverbally affirmed it did not bother him. During an interview on 2/18/16, at 3:07 p.m. the director of nursing (DON), verified bowel functions and medications should not be talked about in the dining room and should be discussed in private. During an observation on 2/17/16, at 10:34 a.m. a laboratory technician obtained a throat swab for	F 164	ensure ongoing monitoring of residents privacy and confidentiality will be maintained. The QAPI will also include audits performed by the DON, MDS Coordinator and/or charge nurse. DON will review with medical staff (physicians) on the current Privacy/Confidentiality policy during their next scheduled medical staff meeting on 3/23/16. All physicians have been re-educated by the DON on 3/8/16 regarding expectations for physician rounds regarding confidentiality/privacy. HIPAA/Compliance Officer was notified and is included in the QAPI as listed above.	

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F 164	Continued From page 3 culture from R16 while in the day room area. There were several other residents in the day room for activities at that time. The laboratory technician asked R16 permission, though did not ask the other residents for their permission. A nursing assistant (NA)-A and another staff were in the area. During an interview on 2/17/16, at 10:35 a.m. NA-A stated they usually do not do lab work in the day room, but this technician was new and probably did not know it would be an issue. The facility policy and procedure for Privacy and Confidentiality dated 6/27/14, indicated the resident had the right to personal privacy and confidentiality of personal and clinical records, including personal cares, communications, and medical treatments. The policy and procedure directed, staff will insure that residents and patients shall have the right to respectfulness and privacy as it relates to their medical and personal care program and case discussion was to be confidential. R16's admission diagnoses included Parkinson's disease, pain, dysphagia and weakness. The 12/15/15, quarterly MDS indicated R16 was cognitively intact and received scheduled pain medications. R16's 9/29/15 annual MDS indicated that having the ability to talk on the phone in private was very important. During an observation on 2/17/16, at 9:23 a.m., R16 was observed sitting in the day room near the TV. At least 6 other residents were in the area, reclining in chairs or sitting at the table. During the observation, medical doctor (MD)-D left the nurses station and approached R16.	F 164		

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F 164	Continued From page 4 MD-D and R16 talked about R16's care and could be overheard from the nurses' station and throughout the day room area. MD-D talked about R16's osteoarthritis, pain, and head cold, indicating that he would have R16's throat swabbed and that R16's hip pain was likely due to the osteoarthritis. In an interview on 2/18/16, at 1:36 p.m., Nursing Assistant (NA)-A stated that she did hear MD-A meet with R16 and another resident in the day room on 2/17/16. NA-A also stated that MD-A had interviewed residents in the day room on previous nursing home rounds.	F 164		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide repositioning and toileting services as directed by the care plan for 1 of 3 residents (R18) reviewed for pressure ulcers and urinary incontinence. Findings include: R18's Diagnosis Summary list dated 12/22/15, indicated R18's diagnoses included altered mental status, weakness and edema. The annual Minimum Data Set (MDS) dated	F 282	F282: It is the policy and practice of the Cook Hospital and Care Center that the residents comprehensive care plan, repositioning and toileting policies be followed as written. DON immediately re-educated all nursing staff on 2/19/16 regarding the following policies: Comprehensive Nursing policy (12/14); Repositioning Policy (6/26/06); and Toileing Residents(7/8/14). A mandatory meeting will be held by the	3/17/16

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F 282	Continued From page 5 1/22/16, indicated R18 was usually understood and was usually able to understand others. R18 had short and long term memory problems and severely impaired decision making skills. R18 was frequently incontinent of bowel and bladder. R18 was at risk for pressure ulcers and had pressure reduction devices on the bed and chair. R18's Risk for Impaired Skin Integrity care plan reviewed on 2/17/16, indicated R18 was at risk for breakdown. R18 had an alternating pressure redistribution mattress on the bed and used a Dry Floatation Air Cushion (Roho) in the chair. The Mobility Deficit care plan reviewed on 2/17/16, indicated R18 had impaired ability to turn side to side, move from standing to sitting, sitting to standing and transfers. The care plan directed staff to assist R18 to reposition every one hour. The Impaired Bladder Elimination care plan reviewed on 2/17/16 indicated R18 had frequent bladder incontinence and was unable to transfer to the toilet. The undated nursing assistant (NA) a.m. and p.m. toileting group sheet directed staff to reposition R18 every one hour and assist R18 to the toilet every one and a half hours. A Care Center Resident Care Plan Summary sheet dated 2/17/16, directed R18 was to be repositioned every one hour. On 2/18/16, R18 was continuously observed from 7:10 a.m. to 9:10 a.m. and neither repositioning or toileting were offered or provided. At 7:10 a.m. R18 was observed in the unit living room across from the nurses station. R18 was sitting in a recliner with her feet elevated. R18 was sitting directly on the seat of the recliner without the	F 282	DON on 3/16/16 and 3/17/16 for all nursing personnel/activity staff and restorative nursing to re-educate on the above named policies. All new employees are currently educated through new employee orientation. A QAPI was developed on 3/8/16 to insure compliance and ongoing monitoring of nursing personnel with toileting and repositioning of residents -following their individualized comprehensive care plan. DON, MDS Coordinator and/or charge nurse will complete this through direct observation. R18 care plan related to repositioning and toileting was reviewed immediately by DON and MDS Coordinator. All nursing personnel were re-educated as to her toileting and repositioning schedule to insure that repositioning is provided every one hour and toileting is provided every one and one-half hour. Staff were also re-educated that R18 is to have her ROHO cushion in her chair of choice at all times to aide in preventing breakdown and to relieve pressure. Audits will be performed on a regular basis by the DON, MDS Coordinator and/or staff nurse to insure compliance with R18 careplan. To prevent similar occurences in the future all residents will be audited as per the QAPI indicated above to insure compliance with their individualized care plan related to toileting and repositioning. As stated this will be performed by the	

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F 282	Continued From page 6 Roho cushion. R18 remained this way until 9:10 a.m. when nursing assistant (NA)-B approached R18 and R18 refused to get up. NA-B then asked NA-A to try. NA-A assisted R18 to stand and ambulate to R18's bathroom. R18's buttocks were observed with NA-A. NA-A verified R18's buttock were red and the incontinent product was wet with urine. After providing incontinence care NA-A applied a barrier cream to R18's buttocks. On 2/18/16, at 9:35 a.m. NA-B stated R18 was toileted and placed in the recliner at 7:00 a.m. NA-B stated R18 was to be repositioned every hour and toileted every one and a half hours. NA-B verified the group sheet directed every one hour repositioning and every one and a half hour toileting. NA-B stated this had not been done as directed. On 2/19/16, from 8:30 a.m. until 8:50 a.m. R18 was observed in the main dining room sitting on the Roho cushion on a dining chair. At 8:50 a.m. R18's buttocks were observed with registered nurse (RN)-A and RN-B. RN-A verified R18's buttocks were a dark red color. The area measured 9 by 13 centimeters (cm) and the area was blanchable. There were no open areas. On 2/19/16, at 9:25 a.m. RN-B verified R18 was to be repositioned every one hour and toileted every one and a half hours. The RN stated the toileting group sheet and the Care Center Resident Care Plan Summary sheet were a summarization of the care plan. The facility's Care Plan Comprehensive-Nursing policy revised on 12/14, indicated the care plan must be followed at all times. The facility's Repositioning policy dated 6/26/06, indicated if a	F 282	DON, MDS Coordinator and/or charge nurse through direct observation audits.	

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F 282	Continued From page 7 resident showed signs of redness before two hour repositioning the resident would then be repositioned every one hour or more often as needed. The facility's Toileting Residents policy revised on 7/8/14, indicated the purpose of the policy was to ensure residents were toileted safely on a routine basis in a timely manner according to their individualized care plan.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care and services were provided for 1 of 3 residents R18 who was at risk for pressure ulcers. Findings include: R18's Diagnosis Summary list dated 12/22/15, indicated R18's diagnoses included altered mental status, weakness and edema. A Tissue Tolerance Assessment (a tool used to determine the ability of the skin and it's supporting structures to endure the effects of	F 314	F314: It is the policy of the Cook Hospital and Care Center to follow each residents individualized care plan as well as the facility Repositioning and Skin Assessment policies. DON immediately re-educated all nursing staff on 2-19-16 regarding the expectations and following policies: Comprehensive Care plan, Repositioning, and Skin Assessment. A mandatory meeting will be held by the	3/17/16

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F 314	Continued From page 8 pressure without adverse effects) dated 4/8/15, indicated R18 had pressure ulcers and had a history of skin issues. The evaluation of the assessment indicated R18 was able to tolerate one hour in bed without signs or symptoms of concern or irritation. R18 refused to sit in the chair to assess for tissue tolerance. R18's Skin Risk Assessment dated 1/15/16, indicated R18 was at risk for skin breakdown due to poor intake and frequent supplement refusals. R18 current weight was 75 pounds. R18 laid in the bed or sat in the recliner most of the time. R18 had a history of pressure areas on the coccyx and ear. R18's skin was very fragile and tore easily. The annual Minimum Data Set (MDS) dated 1/22/16, indicated R18 usually understood and was usually able to understand others. R18 had short and long term memory problems and severely impaired decision making skills. R18 needed the extensive assistance of one staff with bed mobility and transfers. R18 was at risk for pressure ulcers and had pressure reduction devices on the bed and chair. The Pressure Ulcer Care Area Assessment (CAA) dated 1/29/16, indicated R18 was at risk for skin breakdown due to fragile skin, frequent incontinence, poor nutritional intake, frequent refusals to reposition and a very slender build with thin skin over bony prominences. Staff attempted to reposition R18 every one hour. R18 also would frequently choose to sleep in the recliner at night which left her on her buttocks for a long period of time. R18's Risk for Impaired Skin Integrity care plan	F 314	DON with all nursing, activities and restorative staff on 3/16/16 and 3/17/16 for a full re-education of the importance of following the Comprehensive Care plan, Repositioning and Skin Assessment policies. New employees will receive education regarding said policies during new employee orientation. A QAPI was created by the DON on 3/8/16 to insure compliance and ongoing monitoring through direct observation audits regarding toileting, skin assessments and repositioning of residents. The DON, MDS Coordinator and/or charge nurse will perform the ongoing audits. R18's Plan of care was reviewed by DON and MDS Coordinator. Staff will provide repositioning every one hour as directed related to her skin risk assessment and tissue tolerance assessment. Staff were immediately re-educated on R18 Care plan related to repositioning need of every one hour. The QAPI noted above will include audits of all current and future residents will be performed by DON and/or MDS Coordinator and Charge nurse through direct observation based on individualized care plans related to repositioning needs.	

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F 314	Continued From page 9	F 314		

reviewed on 2/17/16, indicated R18 was at risk for breakdown. The care plan directed staff to use gentle care with cares due to easy bruising and tears to the skin. R18 had an alternating pressure redistribution mattress on the bed and used a Dry Floatation Air Cushion (Roho) in the chair. The Mobility Deficit care plan reviewed on 2/17/16, indicated R18 had impaired ability to turn side to side, move from standing to sitting, sitting to standing and transfers. The care plan directed staff to assist R18 to reposition every one hour.

The undated nursing assistant (NA) a.m. and p.m. toileting group sheet directed staff to reposition R18 every one hour and assist R18 to the toilet every one and a half hours.

A Care Center Resident Care Plan Summary sheet dated 2/17/16, identified R18 had a Roho cushion on the chair, a redistribution mattress on the bed and staff to reposition every hour.

The Daily Skin Care Documentation reviewed from 12/21/15 through 2/19/16, indicated R18's buttocks were red. Most days the buttocks were left open to air. On 12/24/15, an enzymatic paste was applied and on 1/20/16 through 1/27/16, a Tegaderm with pad (a transparent waterproof dressing used to protect wounds) was applied. The daily documentation lacked an assessment of the skin condition of the buttocks.

On 2/18/16, R18 was continuously observed from 7:10 a.m. to 9:10 a.m. and repositioning was not offered or provided. At 7:10 a.m. R18 was observed in the unit living room across from the nurses station. R18 was sitting in a recliner with her feet elevated. R18 was sitting directly on the seat of the recliner. R18 remained this way until

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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 314	Continued From page 10 9:10 a.m. when nursing assistant (NA)-B approached R18 and R18 refused to get up. NA-B asked NA-A to attempt to get R18 up. NA-A assisted R18 to stand and ambulate to R18's bathroom. R18's buttocks were observed with NA-A. NA-A verified R18's buttock were red and R18's incontinent product was wet with urine. After providing incontinence care NA-A applied a barrier cream to R18's buttocks. On 2/18/16, at 9:35 a.m. NA-B stated R18 was put on the recliner at 7:00 a.m. The NA stated R18 was to be repositioned every one hour and toileted every one and a half hours. The NA verified the group sheet directed every one hour repositioning and every one and a half hour toileting. The NA verified this had not been done as directed. On 2/19/16, from 8:30 a.m. until 8:50 a.m. R18 was observed in the main dining room sitting on the Roho cushion on a dining chair. At 8:50 a.m. R18's buttocks were observed with registered nurse (RN)-A and RN-B. RN-A verified R18's buttocks were a dark red color. The area measured 9 by 13 centimeters (cm) and the area was blanchable. There were no open areas. On 2/19/16, at 9:25 a.m. RN-B verified R18 was to be repositioned every one hour and toileted every one and a half hours. The RN stated the toileting group sheet and the Care Center Resident Care Plan Summary sheet were a summarization of the care plan. RN-B verified the Daily Skin Care Documentation indicated R18's buttocks were documented as being red and lacked assessment of the area. The RN further stated R18's had a history of pressure ulcers and R18's skin was very fragile.	F 314		

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F 314	Continued From page 11 The facility's Repositioning policy dated 6/26/06, indicated a Tissue Tolerance Assessment would be done on all residents unable to reposition independently in the bed or chair. If a resident showed signs of redness before two hour repositioning the resident would then be repositioned every one hour or more often as needed. The facility's Skin Assessment policy dated 6/28/06, indicated all identified areas would be measured and documented.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure incontinence care and services were provided for 1 of 3 residents R18 reviewed for urinary incontinence. Findings include: R18's Diagnosis Summary list dated 12/22/15,	F 315	F315: It is the policy of the Cook Hospital and Care Center that employees follow a residents individualized care plan which includes toileting; and Comprehensive Care plan. DON immediately provided a re-education	3/17/16

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F 315	Continued From page 12 indicated R18's diagnoses included altered mental status, weakness and edema. The annual Minimum Data Set (MDS) dated 1/22/16, indicated R18 usually understood and was usually able to understand others. R18 had short and long term memory problems and severely impaired decision making skills. R18 needed the extensive assistance of one staff with toileting and personal hygiene. R18 was frequently incontinent of bowel and bladder. The Urinary Incontinence Care Area Assessment (CAA) dated 1/29/16, indicated R18 was frequently incontinent of urine and required the assistance of one staff to complete toileting needs. R18 was to be toileted every one and a half hours, as needed, and when requested or soiled due to frequent incontinence and fragile skin. The Impaired Bladder Elimination care plan reviewed on 2/17/16 indicated R18 had frequent bladder incontinence and was unable to transfer to the toilet. The undated nursing assistant (NA) a.m. and p.m. toileting group sheet directed staff to assist R18 to the toilet every one and a half hours. The toileting group sheet further indicated R18 was frequently incontinent of urine. A Care Center Resident Care Plan Summary sheet dated 2/17/16, directed R18 may be left in the bathroom unattended. On 2/18/16, R18 was continuously observed from 7:10 a.m. to 9:10 a.m. and toileting was not offered or provided. At 7:10 a.m. R18 was	F 315	on 2/19/16 to the nursing department to insure that the individualized care plan and toileting plans are followed as written. A mandatory meeting will be held by DON on 3/16/16 and 3/17/17 to re-educate all nursing, activities and restorative staff on the Comprehensive Care plan including the toileting policy and following their individualized care plans and toileting group sheets. All new employees will be educated during their new employee orientation. A QAPI was created by the DON on 3/8/16 to insure compliance and ongoing monitoring with the residents individualized care plan including the toileting plan. DON, MDS Coordinator, and/or charge nurses will audit through direct observation as well as verification that the residents specific toileting group sheets are followed as written. R18 Care plan was reviewed by the DON and MDS Coordinator. All staff were re-educated immediately on residents individualized care plan regarding her need for toileting every one and one-half hours and as needed. Resident will be toileted at every one and one-half hours and as needed. The QAPI noted above includes ongoing monitoring and compliance for individualized toileting plans accomplished through direct observation audits for all current and future residents. These audits will be performed by the DON, MDS	

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F 315	Continued From page 13 observed in the unit living room across from the nurses station. R18 remained there until 9:10 a.m. when nursing assistant (NA)-B approached R18 and R18 refused to get up. NA-B asked NA-A to attempt to get R18 up. NA-A assisted R18 to stand and ambulate to R18's bathroom. NA-A verified R18's buttock were red and R18's incontinent product was wet with urine. After providing incontinence care NA-A applied a barrier cream to R18's buttocks. On 2/18/16, at 9:35 a.m. NA-B stated R18 was toileted and then put in the recliner at 7:00 a.m. NA-B stated R18 was to be toileted every one and a half hours. The NA verified the group sheet directed every one and a half hour toileting. NA-B verified this had not been done as directed. On 2/19/16, at 9:25 a.m. RN-B verified R18 was to be toileted every one and a half hours. The facility's Care Plan Comprehensive-Nursing policy revised on 12/14, indicated the care plan would describe the services that were to be furnished to attain or maintain the residents highest practicable physical, mental and psychosocial well being. The facility's Toileting Residents policy revised on 7/8/14, indicated the purpose of the policy was to ensure residents were toileted safely on a routine basis in a timely manner according to their individualized care plan.	F 315	Coordinator and/or charge nurse.	

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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 substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/08/2016

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 Marian.Whitney@state.mn.us or 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, and 2005 The original building buildings and additions are all Type II (111) construction, therefore, the facility was inspected as one building. The facility has a clinic, hospital and an administrative wing that are properly separated from the nursing home. 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 licensed capacity of 28 beds and had a census of 27 at the time of the survey. The requirement at 42 CFR, Subpart 485.623 (d)	K 000		

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K 000	Continued From page 2 is NOT MET.	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 2 of several smoke barrier walls construction that meet the requirements of NFPA 101 - 2000 edition, Sections 19-3.7.3 and 8.3. This deficient practice could affect 27 of 27 residents, staff and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 11:00 AM to 3:00 PM on 02/17/2016, observation revealed the following deficient conditions affecting the facility's smoke barrier walls, 1. There was a penetration around an electrical conduit and a 6 inch by 18 inch opening above the ceiling tile in the smoke barrier that is located by resident room 104, and 2. there is a 6 inch by 6 inch opening above the ceiling tile in the smoke barrier that is located by the annex doors. This deficient condition was verified by a Maintenance Supervisor.	K 025	K25: The penetration around the electrical conduit and the 6 inch by 18 inch opening above the ceiling tile in the smoke barrier located by resident room 104 and the 6 inch by 6 inch opening above the ceiling tile in the smoke barrier that is located by the annex doors have been patched/repaired and fire barrier sealant was applied.	2/29/16

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K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (00) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities residents, staff and visitors. Findings include: On facility tour between 11:00 AM to 3:00 PM on 02/17/2016, observation revealed that there is a vertical penetration around the hydraulic pipe and a horizontal penetration around the fire sprinkler pipe that are located within the elevator control/mechanical room. This deficient condition was verified by a Maintenance Supervisor.	K 029	K29: The vertical penetration around the hydraulic pipe and a horizontal penetration around the fire sprinkler pipe located within the elevator control/mechanical room have been patched/repaired and fire sealant was applied.	2/29/16
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		3/21/16

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K 050	Continued From page 4 Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of 27 of 27 residents. Findings include: On facility tour between 11:00 AM to 3:00 PM on 02/17/2016, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was revealed that the facility had the following deficient conditions affecting the facility's fire drills: 1. The facility could not provide documentation for 1 Day shift fire drill in the 1st calendar quarter. 2. The facility could not provide documentation for 1 Overnight shift fire drill in the 2nd calendar quarter. 3. The facility could not provide documentation for	K 050	K50: The Plant Manager will review all paperwork immediately or as soon as possible after a fire drill to make sure the drill was documented and the times of the drills are included on the form. A QAPI will be developed by 3/21/16 to make sure forms are filled out during a fire drill and that all forms have all required documentation. The Plant Manager will review the forms and dcoumentation on a monthly basis and enter the results each quarter on the QAPI that corresponds with this tag.	

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K 050	Continued From page 5 1 Evening shift fire drill in the 3rd calendar quarter. This deficient condition was verified by a Maintenance Supervisor.	K 050		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4., 19.3.6.3.2, 19.3.6.3.3, and 9.6, as well as 1999 NFPA 72, Sections 7.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 27 of 27 residents, staff, and visitors of the facility. Findings include: On facility tour between 11:00 AM to 3:00 PM on 02/17/2016, observations revealed that during the review of all available fire drill reports and fire alarm maintenance/testing documentation for the last 12 months and an interview with the Maintenance Supervisor, it was revealed that the facility failed to document and/or verify 4 of 12 monthly tests of the digital alarm communicator transmitter (DACT).	K 052	K52: The Plant Manager will review fire drill paperwork immediately or as soon as possible after each fire drill to make sure the confirmation from WH Response for the DACT Test and the name of the employee that has conducted the fire drill has been documented on the fire drill report form. A QAPI will be developed by 3/21/16. The Plant Manager will audit all fire drill report forms for the documentation of the WH Response for the DACT Test and documentation of the name of the employee that conducted the fire drill. The Plant Manager will audit forms monthly and document the results on the QAPI that has been developed.	3/21/16

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K 052	Continued From page 6 This deficient condition was verified by a Maintenance Supervisor.	K 052		
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not conducted that required sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code (99), Sec. 7-3.2.1. This deficient practice could affect 27 of 27 residents, visitors, and staff. Findings include: On facility tour between 11:00 AM to 3:00 PM on 02/17/2016, a review of the facility's available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Supervisor revealed that at the time of the inspection the facility could not provide any current documentation verifying the completion of the required sensitivity testing of each smoke detector located throughout the facility. This deficient practices was confirmed by the Maintenance Supervisor.	K 054	K54: The Plant Manager will be scheduling Nardini to perform the required sensitivity testing of the smoke detectors on the fire alarm system. This will be scheduled by 3/25/16. The Plant Manager has placed a reminder on his outlook calendar for the two year reminder.	3/25/16
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested	K 062		3/3/16

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K 062	Continued From page 7 periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect 27 of 27 residents, staff and visitors. Findings include: On facility tour between 11:00 AM to 3:00 PM on 02/17/2016, a review of documentation and interview with the Maintenance Supervisor revealed that at the time of the inspection the facility could not provide any documentation for 1 of 4 quarterly fire sprinkler flow test having been completed. This deficient condition was verified by a Maintenance Supervisor.	K 062	K62: We have elected to use the Categorical Waiver for Extinguishing Requirements. A copy of this waiver is attached. The Plant Manager will be conducting semi-annual fire sprinkler flow tests.	
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by:	K 072		3/14/16

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	245392	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/17/2016**

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K 072	Continued From page 8 Based on observations the facility failed to keep the means of egress continuous and free of all obstructions or impediments to full instant use in the case of fire or other emergency, in accordance with NFPA Life Safety Code 101 (2000 edition) Chapter 7, Section 7.1.10. These obstructions could interfere with the convenient and effective removal all residents, staff and visitors in an emergency situation, and impede fire fighting operations during a fire emergency. Findings include: On facility tour between 11:00 AM to 3:00 PM on 02/17/2016 during the facility tour it was observed that there are chairs in the corridor outside the Adult Day Service office creating a waiting area and there is a copier that is being used obstructing the same exit corridor. This deficient condition was verified by a Maintenance Supervisor.	K 072	K72: The Plant Manager has moved the chairs into the Adult Day Stay area so they are no longer in the hallway. The copy machine will be moved out of the hallway on 3/14/16 when the IT Director returns.	
K 075 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to store large trash and linen carts in properly protected rooms in accordance	K 075	K75: The multiple binned mobile soiled linen containers that are larger than the 32	3/11/16

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K 075	Continued From page 9 with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.7.5.5. This deficient practice could affect the safety of all residents, staff and visitors if smoke or fire from one of these carts rendered the corridors untenable. Findings include: On facility tour between 11:00 AM to 3:00 PM on 02/17/2016, it was found in that the facility was storing multiple binned mobile solid linen container that has an aggregate capacity that is greater than 32 gallons being stored in the corridor across from room 108, and not in the required hazardous storage areas. This deficient condition was verified by a Maintenance Supervisor.	K 075	gallon aggregate capacity are stored in the hazardous storage area and will be removed when the new receptacles arrive. Smaller capacity soiled linen/trash collection receptacles will be ordered by 3/11/16. One receptacle will be ordered for each of the two hallways. As stated above, when these arrive the larger ones will be removed from use.	

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 2, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5392026

Dear Ms. Debevec:

The above facility was surveyed on February 16, 2016 through February 19, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency 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 attached Minnesota Department of Health orders being submitted 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 after the

statement, "This Rule 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 Lyla Burkman at (218) 308-2104 (email: lyla.burkman@state.mn.us) or Chris Campbell at: (218) 302-6151 (email: chris.campbell@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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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 _____	02/19/2016

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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 February 16, 17, 18, 19, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and Certification Program; 11 East Superior Street; Suite 290, Duluth, MN 55802 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,	2 000		

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2 000	Continued From page 2 "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.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide repositioning and toileting services as directed by the care plan for 1 of 3 residents (R18) reviewed for pressure ulcers and urinary incontinence. Findings include: R18's Diagnosis Summary list dated 12/22/15, indicated R18's diagnoses included altered mental status, weakness and edema. The annual Minimum Data Set (MDS) dated 1/22/16, indicated R18 was usually understood and was usually able to understand others. R18 had short and long term memory problems and severely impaired decision making skills. R18 was frequently incontinent of bowel and bladder. R18 was at risk for pressure ulcers and had	2 565	CORRECTED	3/17/16

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2 565	Continued From page 3 pressure reduction devices on the bed and chair. R18's Risk for Impaired Skin Integrity care plan reviewed on 2/17/16, indicated R18 was at risk for breakdown. R18 had an alternating pressure redistribution mattress on the bed and used a Dry Floatation Air Cushion (Roho) in the chair. The Mobility Deficit care plan reviewed on 2/17/16, indicated R18 had impaired ability to turn side to side, move from standing to sitting, sitting to standing and transfers. The care plan directed staff to assist R18 to reposition every one hour. The Impaired Bladder Elimination care plan reviewed on 2/17/16 indicated R18 had frequent bladder incontinence and was unable to transfer to the toilet. The undated nursing assistant (NA) a.m. and p.m. toileting group sheet directed staff to reposition R18 every one hour and assist R18 to the toilet every one and a half hours. A Care Center Resident Care Plan Summary sheet dated 2/17/16, directed R18 was to be repositioned every one hour. On 2/18/16, R18 was continuously observed from 7:10 a.m. to 9:10 a.m. and neither repositioning or toileting were offered or provided. At 7:10 a.m. R18 was observed in the unit living room across from the nurses station. R18 was sitting in a recliner with her feet elevated. R18 was sitting directly on the seat of the recliner without the Roho cushion. R18 remained this way until 9:10 a.m. when nursing assistant (NA)-B approached R18 and R18 refused to get up. NA-B then asked NA-A to try. NA-A assisted R18 to stand and ambulate to R18's bathroom. R18's buttocks were observed with NA-A. NA-A verified R18's buttock were red and the incontinent product was	2 565		

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2 565	Continued From page 4 wet with urine. After providing incontinence care NA-A applied a barrier cream to R18's buttocks. On 2/18/16, at 9:35 a.m. NA-B stated R18 was toileted and placed in the recliner at 7:00 a.m. NA-B stated R18 was to be repositioned every hour and toileted every one and a half hours. NA-B verified the group sheet directed every one hour repositioning and every one and a half hour toileting. NA-B stated this had not been done as directed. On 2/19/16, from 8:30 a.m. until 8:50 a.m. R18 was observed in the main dining room sitting on the Roho cushion on a dining chair. At 8:50 a.m. R18's buttocks were observed with registered nurse (RN)-A and RN-B. RN-A verified R18's buttocks were a dark red color. The area measured 9 by 13 centimeters (cm) and the area was blanchable. There were no open areas. On 2/19/16, at 9:25 a.m. RN-B verified R18 was to be repositioned every one hour and toileted every one and a half hours. The RN stated the toileting group sheet and the Care Center Resident Care Plan Summary sheet were a summarization of the care plan. The facility's Care Plan Comprehensive-Nursing policy revised on 12/14, indicated the care plan must be followed at all times. The facility's Repositioning policy dated 6/26/06, indicated if a resident showed signs of redness before two hour repositioning the resident would then be repositioned every one hour or more often as needed. The facility's Toileting Residents policy revised on 7/8/14, indicated the purpose of the policy was to ensure residents were toileted safely on a routine basis in a timely manner according to their individualized care plan.	2 565		

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2 565	Continued From page 5 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or his/her designee could develop and implement systems to ensure resident plans of care are available and implemented by staff. The DON or his/her designee could educate all appropriate staff. The DON or his/her designee could monitor this process to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care and services were provided for 1 of 3 residents R18 who was at risk for pressure ulcers. Findings include: R18's Diagnosis Summary list dated 12/22/15, indicated R18's diagnoses included altered mental status, weakness and edema.	2 905	CORRECTED	3/17/16

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2 905	Continued From page 6 A Tissue Tolerance Assessment (a tool used to determine the ability of the skin and it's supporting structures to endure the effects of pressure without adverse effects) dated 4/8/15, indicated R18 had pressure ulcers and had a history of skin issues. The evaluation of the assessment indicated R18 was able to tolerate one hour in bed without signs or symptoms of concern or irritation. R18 refused to sit in the chair to assess for tissue tolerance. R18's Skin Risk Assessment dated 1/15/16, indicated R18 was at risk for skin breakdown due to poor intake and frequent supplement refusals. R18 current weight was 75 pounds. R18 laid in the bed or sat in the recliner most of the time. R18 had a history of pressure areas on the coccyx and ear. R18's skin was very fragile and tore easily. The annual Minimum Data Set (MDS) dated 1/22/16, indicated R18 usually understood and was usually able to understand others. R18 had short and long term memory problems and severely impaired decision making skills. R18 needed the extensive assistance of one staff with bed mobility and transfers. R18 was at risk for pressure ulcers and had pressure reduction devices on the bed and chair. The Pressure Ulcer Care Area Assessment (CAA) dated 1/29/16, indicated R18 was at risk for skin breakdown due to fragile skin, frequent incontinence, poor nutritional intake, frequent refusals to reposition and a very slender build with thin skin over bony prominences. Staff attempted to reposition R18 every one hour. R18 also would frequently choose to sleep in the recliner at night which left her on her buttocks for a long period of time.	2 905		

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2 905	Continued From page 7 R18's Risk for Impaired Skin Integrity care plan reviewed on 2/17/16, indicated R18 was at risk for breakdown. The care plan directed staff to use gentle care with cares due to easy bruising and tears to the skin. R18 had an alternating pressure redistribution mattress on the bed and used a Dry Floatation Air Cushion (Roho) in the chair. The Mobility Deficit care plan reviewed on 2/17/16, indicated R18 had impaired ability to turn side to side, move from standing to sitting, sitting to standing and transfers. The care plan directed staff to assist R18 to reposition every one hour. The undated nursing assistant (NA) a.m. and p.m. toileting group sheet directed staff to reposition R18 every one hour and assist R18 to the toilet every one and a half hours. A Care Center Resident Care Plan Summary sheet dated 2/17/16, identified R18 had a Roho cushion on the chair, a redistribution mattress on the bed and staff to reposition every hour. The Daily Skin Care Documentation reviewed from 12/21/15 through 2/19/16, indicated R18's buttocks were red. Most days the buttocks were left open to air. On 12/24/15, an enzymatic paste was applied and on 1/20/16 through 1/27/16, a Tegaderm with pad (a transparent waterproof dressing used to protect wounds) was applied. The daily documentation lacked an assessment of the skin condition of the buttocks. On 2/18/16, R18 was continuously observed from 7:10 a.m. to 9:10 a.m. and repositioning was not offered or provided. At 7:10 a.m. R18 was observed in the unit living room across from the nurses station. R18 was sitting in a recliner with her feet elevated. R18 was sitting directly on the	2 905		

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2 905	Continued From page 8 seat of the recliner. R18 remained this way until 9:10 a.m. when nursing assistant (NA)-B approached R18 and R18 refused to get up. NA-B asked NA-A to attempt to get R18 up. NA-A assisted R18 to stand and ambulate to R18's bathroom. R18's buttocks were observed with NA-A. NA-A verified R18's buttock were red and R18's incontinent product was wet with urine. After providing incontinence care NA-A applied a barrier cream to R18's buttocks. On 2/18/16, at 9:35 a.m. NA-B stated R18 was put on the recliner at 7:00 a.m. The NA stated R18 was to be repositioned every one hour and toileted every one and a half hours. The NA verified the group sheet directed every one hour repositioning and every one and a half hour toileting. The NA verified this had not been done as directed. On 2/19/16, from 8:30 a.m. until 8:50 a.m. R18 was observed in the main dining room sitting on the Roho cushion on a dining chair. At 8:50 a.m. R18's buttocks were observed with registered nurse (RN)-A and RN-B. RN-A verified R18's buttocks were a dark red color. The area measured 9 by 13 centimeters (cm) and the area was blanchable. There were no open areas. On 2/19/16, at 9:25 a.m. RN-B verified R18 was to be repositioned every one hour and toileted every one and a half hours. The RN stated the toileting group sheet and the Care Center Resident Care Plan Summary sheet were a summarization of the care plan. RN-B verified the Daily Skin Care Documentation indicated R18's buttocks were documented as being red and lacked assessment of the area. The RN further stated R18's had a history of pressure ulcers and R18's skin was very fragile.	2 905		

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2 905	Continued From page 9 The facility's Repositioning policy dated 6/26/06, indicated a Tissue Tolerance Assessment would be done on all residents unable to reposition independently in the bed or chair. If a resident showed signs of redness before two hour repositioning the resident would then be repositioned every one hour or more often as needed. The facility's Skin Assessment policy dated 6/28/06, indicated all identified areas would be measured and documented. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or his/her designee could develop and implement systems to ensure residnet's received pressure ulcer treatment and prevention based on a comprehensive assessment and plan of care. The DON or his/her designee could educate all appropriate staff. The DON or his/her designee could monitor this process to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates	2 910		3/17/16

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2 910	Continued From page 10 that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure incontinence care and services were provided for 1 of 3 residents R18 reviewed for urinary incontinence. Findings include: R18's Diagnosis Summary list dated 12/22/15, indicated R18's diagnoses included altered mental status, weakness and edema. The annual Minimum Data Set (MDS) dated 1/22/16, indicated R18 usually understood and was usually able to understand others. R18 had short and long term memory problems and severely impaired decision making skills. R18 needed the extensive assistance of one staff with toileting and personal hygiene. R18 was frequently incontinent of bowel and bladder. The Urinary Incontinence Care Area Assessment (CAA) dated 1/29/16, indicated R18 was frequently incontinent of urine and required the assistance of one staff to complete toileting needs. R18 was to be toileted every one and a half hours, as needed, and when requested or soiled due to frequent incontinence and fragile skin.	2 910	CORRECTED	

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2 910	Continued From page 11 The Impaired Bladder Elimination care plan reviewed on 2/17/16 indicated R18 had frequent bladder incontinence and was unable to transfer to the toilet. The undated nursing assistant (NA) a.m. and p.m. toileting group sheet directed staff to assist R18 to the toilet every one and a half hours. The toileting group sheet further indicated R18 was frequently incontinent of urine. A Care Center Resident Care Plan Summary sheet dated 2/17/16, directed R18 may be left in the bathroom unattended. On 2/18/16, R18 was continuously observed from 7:10 a.m. to 9:10 a.m. and toileting was not offered or provided. At 7:10 a.m. R18 was observed in the unit living room across from the nurses station. R18 remained there until 9:10 a.m. when nursing assistant (NA)-B approached R18 and R18 refused to get up. NA-B asked NA-A to attempt to get R18 up. NA-A assisted R18 to stand and ambulate to R18's bathroom. NA-A verified R18's buttock were red and R18's incontinent product was wet with urine. After providing incontinence care NA-A applied a barrier cream to R18's buttocks. On 2/18/16, at 9:35 a.m. NA-B stated R18 was toileted and then put in the recliner at 7:00 a.m. NA-B stated R18 was to be toileted every one and a half hours. The NA verified the group sheet directed every one and a half hour toileting. NA-B verified this had not been done as directed. On 2/19/16, at 9:25 a.m. RN-B verified R18 was to be toileted every one and a half hours.	2 910		

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2 910	Continued From page 12 The facility's Care Plan Comprehensive-Nursing policy revised on 12/14, indicated the care plan would describe the services that were to be furnished to attain or maintain the residents highest practicable physical, mental and psychosocial well being. The facility's Toileting Residents policy revised on 7/8/14, indicated the purpose of the policy was to ensure residents were toileted safely on a routine basis in a timely manner according to their individualized care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or his/her designee could develop and implement systems to ensure residents were toileted based on a comprehensive assessment and plan of care. The DON or his/her designee could educate all appropriate staff. The DON or his/her designee could monitor this process to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene,	21855		3/23/16

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21855	Continued From page 13 except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure privacy of personal status and care information for 2 of 2 residents (R28, R16) who were observed to have personal care completed and medical information discussed in public areas. Findings include: R28's quarterly Minimum Data Set (MDS) assessment dated 2//8/16, indicated R28 had a severe cognitive impairment, adequate hearing, was nonverbal, was able to understand others, and was usually understood. R28's physician visit notes dated 2/17/16, indicated R28's diagnoses included aphasia (inability to speak or verbalize clearly) and constipation. R28's care plan initiated 8/17/15, indicated R28 had an impairment of bowel elimination and the goal was to have bowel movements every 1-3 days. R28's care plan further indicated R28 had impaired communication due to an impaired ability to speak and a cognitive deficit with the inability to make choices and decisions. R28's physician orders dated 2/17/16, included Docusate/Senna 50/8.6 milligrams (mg) twice daily and Bisacodyl 10 mg daily as needed for constipation. During an observation on 2/18/16, at 8:37 a.m.	21855	CORRECTED	

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21855	Continued From page 14 registered nurse (RN)-C loudly asked R28 if he would take pills to help him go to the bathroom. R28 was leaving the dining room after breakfast and there were 13 other residents and 6 other staff present in the dining room. R28 declined the medication. RN-C loudly stated that he had not had a bowel movement for 5 days and explained that they were the little round pills to help him go to the bathroom. RN-C stated again, that it had been 5 days and asked why he did not want to take them. R28 continued to decline to take the medication, and left the dining room. During an interview on 2/18/16, at 12:44 p.m. RN-C verified she had asked R28 about taking his bowel medications while in the dining room. RN-C verified she did ask R28 about his medications, and stated she could have asked him in his room. RN-C verified it was private information. During an interview on 2/18/16, at 1:32 p.m., R28 confirmed being asked about his bowel medications in the dining room, and nonverbally affirmed it did not bother him. During an interview on 2/18/16, at 3:07 p.m. the director of nursing (DON), verified bowel functions and medications should not be talked about in the dining room and should be discussed in private. During an observation on 2/17/16, at 10:34 a.m. a laboratory technician obtained a throat swab for culture from R16 while in the day room area. There were several other residents in the day room for activities at that time. The laboratory technician asked R16 permission, though did not ask the other residents for their permission. A nursing assistant (NA)-A and another staff were in	21855		

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21855	Continued From page 15 the area. During an interview on 2/17/16, at 10:35 a.m. NA-A stated they usually do not do lab work in the day room, but this technician was new and probably did not know it would be an issue. The facility policy and procedure for Privacy and Confidentiality dated 6/27/14, indicated the resident had the right to personal privacy and confidentiality of personal and clinical records, including personal cares, communications, and medical treatments. The policy and procedure directed, staff will insure that residents and patients shall have the right to respectfulness and privacy as it relates to their medical and personal care program and case discussion was to be confidential. R16's admission diagnoses included Parkinson's disease, pain, dysphagia and weakness. The 12/15/15, quarterly MDS indicated R16 was cognitively intact and received scheduled pain medications. R16's 9/29/15 annual MDS indicated that having the ability to talk on the phone in private was very important. During an observation on 2/17/16, at 9:23 a.m., R16 was observed sitting in the day room near the TV. At least 6 other residents were in the area, reclining in chairs or sitting at the table. During the observation, medical doctor (MD)-D left the nurses station and approached R16. MD-D and R16 talked about R16's care and could be overheard from the nurses' station and throughout the day room area. MD-D talked about R16's osteoarthritis, pain, and head cold, indicating that he would have R16's throat swabbed and that R16's hip pain was likely due to	21855		

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21855	Continued From page 16 the osteoarthritis. In an interview on 2/18/16, at 1:36 p.m., Nursing Assistant (NA)-A stated that she did hear MD-A meet with R16 and another resident in the day room on 2/17/16. NA-A also stated that MD-A had interviewed residents in the day room on previous nursing home rounds. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or his/her designee could develop and implement systems to ensure resident privacy was appropriately provided by all facility staff, including outside providers/services. The DON or his/her designee could educate all appropriate staff. The DON or his/her designee could monitor this process to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21855		