### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 616J

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PAR	Γ I - TO BE COM	PLETED BY T	HE STATI	E SURVEY	AGENCY	F	acility ID: 00586
MEDICARE/MEDICAID PROVID     (L1) 245392     2.STATE VENDOR OR MEDICAID 1     (L2) 752547802		3. NAME AND ADD (L3) COOK COM (L4) 10 SOUTHE. (L5) COOK, MN	IMUNITY HOSP	ITAL C&N	C (L6) 55723		4. TYPE OF ACTION:  1. Initial  3. Termination  5. Validation	7 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SUB	PPLIER CATEGOR	Y 09 ESRD	02 13 PTIP	(L7) 22 CLIA	7. On-Site Visit  8. Full Survey After Co	9. Other mplaint
6. DATE OF SURVEY 0 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJG 2 AOA 3 Od		02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPIG	CE	FISCAL YEAR ENDING 12/31	DATE: (L35)
11LTC PERIOD OF CERTIFICATIO From (a): To (b):  12.Total Facility Beds 13.Total Certified Beds	28 (L18) 28 (L17)	X A. In Complian Program Re Compliance1. A B. Not in Com	quirements	n	34.	pproved Waivers Of The Technical Personnel 24 Hour RN 7-Day RN (Rural SNF) Life Safety Code A*	Following Requirements:  6. Scope of Serv 7. Medical Direc 8. Patient Room S 9. Beds/Room (L12)	tor
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 S 28 (L37) (L38)	NF 19 SNF	ICF (L42)	IID (L43)		15. FACILI 1861 (e) (	TY MEETS 1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICABLE	SHOW LTC CANCELL	LATION DATE):					
17. SURVEYOR SIGNATURE  Kathie Killo	ran, HFE NE I	Date :	03/25/2016	(L19)		survey agency ap JohnsTon, Pr	ogram Specialis	Date: 05/03/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE O	OR SINGLE STAT	E AGENCY	
19. DETERMINATION OF ELIGIBI  _X 1. Facility is Eligible t  2. Facility is not Eligi	o Participate		MPLIANCE WITH C	EIVIL	21.		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	u-1513)
22. ORIGINAL DATE  OF PARTICIPATION  12/01/1986  (L24)	23. LTC AGREEM BEGINNING (L41)		24. LTC AGREEME ENDING DATE (L25)		VOLUNTAL 01-Merger, 0		INVOLUNT 05-Fail to Mo	L30)  ARY eet Health/Safety eet Agreement
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIV A. Suspension	of Admissions:	(L44) (L45)			avoluntary Termination	OTHER 07-Provider 00-Active	Status Change
28. TERMINATION DATE:	(L28)	03001		(L31)	30. REMAR	KS		
31. RO RECEIPT OF CMS-1539	(L32)	2. DETERMINATION ( 04/04/2016	OF APPROVAL DA	ΓΕ (L33)	DETERM	IINATION APPRO	VAL	
				1				



### 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.

Cook Community Hospital C&nc April 8, 2016 Page 2

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



#### 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.

Cook Community Hospital C&nc April 8, 2016 Page 2

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

	POST-	-CERTIFIC	ATION REVISIT RE	EPORT					
PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONS	TRUCTION			DATE OF REVISIT				
IDENTIFICATION NUMBER 245392	A. Building B. Wing			Y2					
NAME OF FACILITY COOK COMMUNITY HOSPITAL	C&NC		<u>'</u>	STREET ADDRESS, CITY, STATE, ZIP CODE  10 SOUTHEAST FIFTH STREET  COOK, MN 55723					
program, to show those deficienc corrected and the date such corre	es previously repo	rted on the CMS-25 ccomplished. Each	Medicaid and/or Clinical Laborato 667, Statement of Deficiencies and deficiency should be fully identifie the CMS-2567 (prefix codes show	Plan of Correction, that have d using either the regulation of	e been or LSC				
ITEM	DATE	ITEM	DATE	ITEM	DATE				
Y4	Y5	Y4	Y5	Y4	Y5				
			-						

Y4		Y5	Y4	Y5	Y4		Y5
ID Prefix	F0164	Correction	ID Prefix F0282	Correctio	n ID Prefix	F0314	Correction
Reg.#	483.10(e), 483.75	Completed	Reg. # 483.20(	(k)(3)(ii) Complete	d Reg.#	483.25(c)	Completed
LSC		03/23/2016	LSC	03/17/2016	LSC		03/17/2016
ID Prefix	F0315	Correction	ID Prefix	Correctio	n ID Prefix		Correction
Reg.#	483.25(d)	Completed	Reg. #	Complete	d Reg.#		Completed
LSC		03/17/2016	LSC ——		LSC		
ID Prefix		Correction	ID Prefix	Correctio	n ID Prefix		Correction
Reg. #		Completed	Reg. #	Complete	d Reg. #		Completed
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correctio	n ID Prefix		Correction
Reg. #		Completed	Reg. #	Complete	d Reg.#		Completed
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correctio	n ID Prefix		Correction
Reg. #		Completed	Reg. #	Complete	d Reg. #		Completed
LSC			LSC		LSC		
REVIEWE STATE AG		REVIEWED BY (INITIALS) CC/KJ	DATE 04/08/2016	SIGNATURE OF SURVEYOR	27200		DATE 03/25/2016
REVIEWE CMS RO	ED BY	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
Form CMS	S - 2567B (09/92)	EF (11/06)	-	Page 1 of 1		EVENT ID:	616J12

### POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	-
IDENTIFICATION NUMBER	A. Building 01 - MAIN BUILDING 01			
245392 <sub>Y1</sub>	B. Wing	Y2	4/5/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
COOK COMMUNITY HOSPITAL O	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).

ITEI Y4		<b>DATE</b> Y5	ITEM Y4			<b>DATE</b> Y5	ITEM Y4			DATE Y5
ID Prefix	NFPA 101	Correction	ID Prefix	NFPA 1	0.1	Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			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 1	01	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 1	01	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			
REVIEWE STATE AG	<b></b> _	REVIEWED BY (INITIALS) TL/KJ	DATE 04/08/2	016	SIGNATURE OF SI		7200		DATE 04/	05/2016
REVIEWE CMS RO	D BY	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						s 🗆 no		



### 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 Weath

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

	0.7.12.10.1			
PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
00586 <sub>Y1</sub>	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).

	,								
ITE	М	DATE	ITEM		DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix	20565 MN Rule 4658.04	Correction	ID Prefix	20905 MN Rule 4658.0525	Correction	ID Prefix	20910 MN Rule 4658.052		Correction
Reg. #	Subp. 3	Completed	Reg. #	Subp. 4	Completed	Reg. #	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 14 Subd. 15	4.651 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			
REVIEWE STATE AG		REVIEWED BY (INITIALS) CC/mm	<b>DATE</b> 05/03/2016	SIGNATURE OF	SURVEYOR 27200			<b>DATE</b> 03/25	5/2016
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
<b>FOLLOW</b> (2/19/2010	JP TO SURVEY CO	OMPLETED ON		CK FOR ANY UNCORRECT ORRECTED DEFICIENCIE:				YES	по по
				Page 1 of 1			EVENT ID:	616J12	

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART 1 - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 616J Facility ID: 00586

	TAKI I-	TO BE COMIT	DETEDDI	IIIE SIAI	IE SURVET AGENCI		racinty ib. 00380
MEDICARE/MEDICAID PROVID     (L1) 245392	ER NO.	3. NAME AND AI (L3) COOK COM			C&NC	4. TYPE OF ACT	ION: <u>2 (</u> L8)  2. Recertification
2.STATE VENDOR OR MEDICAID	NO.	(L4) 10 SOUTHE	EAST FIFTH S	STREET		3. Termination	4. CHOW
(L2) <b>752547802</b>		(L5) COOK, MN			(L6) <b>55723</b>	5. Validation 7. On-Site Visit	6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEO	GORY	<u>02</u> (L7)	8. Full Survey Aft	
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	o. Pun survey An	ст сопрати
6. DATE OF SURVEY <b>02/1</b>	<b>9/2016</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR END	DING DATE: (L35)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID			) (E33)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31	
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	AS:			
From (a):		A. In Complia	ance With		And/Or Approved Waivers Of	The Following Require	ments:
To (b):		~	equirements		2. Technical Personnel	6. Scope of	Services Limit
		Compliance	e Based On:		3. 24 Hour RN	7. Medical I	Director
12. Total Facility Beds	<b>28</b> (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	NF) 8. Patient Ro	oom Size
13.Total Certified Beds	28 (L17)	X B. Not in Con	nnliance with Pro	aram	5. Life Safety Code	9. Beds/Roo	m
13.10tal Celtified Beds	20 (E17)		and/or Applied	-	* Code: <b>B*</b>	(L12)	
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
28							
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY		Date:
N. H. WIII LIEF NEIL		0	02/11/2016			Meath	
Kathie Killoran, HFE NEII			03/11/2016	(L19)	Enforcem	nent Specialist	04/01/2016 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR SINGLE S	STATE AGENCY	
19. DETERMINATION OF ELIGIBI	LITY		MPLIANCE WIT	H CIVIL	21. 1. Statement of Fina	ncial Solvency (HCFA-2: ol Interest Disclosure Stn	
X 1. Facility is Eligible to	Participate	RIGI	HTS ACT:		3. Both of the Above		II (HCFA-1313)
2. Facility is not Eligible							
	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREE	MENT	26. TERMINATION ACTION	:	(L30)
OF PARTICIPATION	BEGINNING	B DATE	ENDING DA	TE	VOLUNTARY 00	<u>INVOLU</u>	JNTARY_
12/01/1986					01-Merger, Closure	05-Fail to	Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-Fail to	o Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS	. ,		03-Risk of Involuntary Termination	on OTHER	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal		der Status Change
			(L44)			00-Activ	re
(L27)	B. Rescind St	uspension Date:					
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	22	. DETERMINATION	J OF APPROVA	LDATE			
51. RO RECEII I OF CIVIS-1339		. DETERMINATION	, OF ALTROVAL	_			
	(L32)			(L33)	DETERMINATION APP	ROVAL	



### 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:

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

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

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

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

Cook Community Hospital C & NC March 2, 2016 Page 2

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

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

### DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by 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.

Cook Community Hospital C & NC March 2, 2016 Page 4

### 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

Cook Community Hospital C & NC March 2, 2016 Page 5

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc</a> 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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 Cook Community Hospital C & NC March 2, 2016 Page 6

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

PRINTED: 03/10/2016 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		PLE CONSTRUCTION  S		TE SURVEY MPLETED
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F 000	INITIAL COMMEN	тѕ	F	000			
	as your allegation of Department's accessorial enrolled in ePOC, year the bottom of the	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required e first page of the CMS-2567 nic submission of the POC will tion of compliance.					
F 164 SS=D	on-site revisit of you validate that substate regulations has been your verification. 483.10(e), 483.75(l)	acceptable electronic POC, an ur facility may be conducted to untial compliance with the en attained in accordance with (4) PERSONAL ENTIALITY OF RECORDS	F 1	164			3/23/16
		e right to personal privacy and or her personal and clinical					
	medical treatment, communications, pe meetings of family a	cludes accommodations, written and telephone ersonal care, visits, and and resident groups, but this e facility to provide a private ent.					
	section, the residen	in paragraph (e)(3) of this t may approve or refuse the and clinical records to any e facility.					
	and clinical records resident is transferr	to refuse release of personal does not apply when the ed to another health care I release is required by law.			·		
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITLE		(X6) DATE

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.

**Electronically Signed** 

03/08/2016

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G	(X3) DATE SURVI	
		245392	B. WING		02/19/201	16
	PROVIDER OR SUPPLIER OMMUNITY HOSPITA			STREET ADDRESS, CITY, STATE, ZIP CODE  10 SOUTHEAST FIFTH STREET  COOK, MN 55723		
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F 164	The facility must ke contained in the resthe form or storage release is required healthcare institution contract; or the resident in the resid	eep confidential all information sident's records, regardless of e methods, except when by transfer to another on; law; third party payment sident.	F 164	4		
	by: Based on observative review, the facility for personal status and residents (R28, R16 personal care comparts discussed in public Findings include:  R28's quarterly Min assessment dated a severe cognitive im	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,		F164: DON immediately re-educated staff verbally on 2/19/16 as it is the policy Cook Hospital and Care Center to our Privacy and Confidentiality policy Mandatory retraining meeting for a center staff to be held on 3-16-16 a 3-17-16. Privacy/Confidentiality of a and dignity will be reviewed following facility policy titled Privacy and Confidentiality (dated 6/27/14). All new employees will be oriented policy during their orientation.	ey of the follow cy. Il care and records ng our	
	R28's physician visindicated R28's diag (inability to speak o constipation.  R28's care plan init had an impairment goal was to have be days. R28's care p impaired communicability to speak and	sit notes dated 2/17/16, agnoses included aphasia or verbalize clearly) and stiated 8/17/15, indicated R28 of bowel elimination and the owel movements every 1-3 olan further indicated R28 had cation due to an impaired d a cognitive deficit with the noices and decisions.		The Lab Director immediately re-ecthe lab personnel verbally on 2-17-new policy titled, "Care Center Res Privacy-Laboratory" dated (3/2016 developed indicating that all reside be taken to a private area for any lacollections. All lab personnel will be educated as indicated by signing of the new policy by March 11, 2016. Iabatory employees will be trained their orientation. * SEE POLICY ATTACHED	16. A ident ) was nts will ab e ff on All new	
	R28's physician ord	ders dated 2/17/16. included		A QAPI was immediately initiated t	.0	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION			(3) DATE SURVEY COMPLETED	
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F 164	daily and Bisacodyl constipation.  During an observat registered nurse (R would take pills to h R28 was leaving th and there were 13 staff present in the medication. RN-C had a bowel mover that they were the lito the bathroom. R been 5 days and as take them. R28 co medication, and left.  During an interview RN-C verified she his bowel medications, and shim in his room. Rinformation.  During an interview confirmed being as medications in the affirmed it did not be director of nursing (functions and medications and medicat	2/8.6 milligrams (mg) twice 10 mg daily as needed for 10 mg daily asked R28 if he nelp him go to the bathroom. It is defined the bathroom after breakfast other residents and 6 other dining room. R28 declined the bathroom and the had not nent for 5 days and explained ittle round pills to help him go N-C stated again, that it had sked why he did not want to natioued to decline to take the the dining room.  In 2/18/16, at 12:44 p.m. and asked R28 about taking ons while in the dining room. It id ask R28 about his rated she could have asked N-C verified it was private  In 2/18/16, at 1:32 p.m., R28 ked about his bowel dining room, and nonverbally	F 1	ensure ongoing monitoring privacy and confidentiality maintained. The QAPI will audits performed by the D Coordinator and/or charged DON will review with medit (physicians) on the current Privacy/Confidentiality politinext scheduled medical st 3/23/16. All physicians have re-educated by the DON or regarding expectations for rounds regarding confident HIPAA/Compliance Officer and is included in the QAF above.	will be also inclu ON, MDS nurse.  cal staff t icy during aff meetin be been on 3/8/16 physician atiality/prive	their ng on acy.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		E SURVEY IPLETED
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F 164	There were several room for activities at technician asked R ask the other resident nursing assistant (It the area.  During an interview NA-A stated they used ay room, but this the probably did not know the facility policy at Confidentiality date resident had the right confidentiality of perincluding personal amedical treatments directed, staff will impatients shall have privacy as it relates care program and confidential.  R16's admission did disease, pain, dyspoon The 12/15/15, quart cognitively intact armedications. R16's that having the ability private was very impouring an observed the TV. At least 6 carea, reclining in chouring the observation of the company of the control of the company of the c	hile in the day room area. I other residents in the day at that time. The laboratory 16 permission, though did not ents for their permission. A NA)-A and another staff were in 2 on 2/17/16, at 10:35 a.m. sually do not do lab work in the echnician was new and ow it would be an issue.  Independent of Privacy and do 6/27/14, indicated the ht to personal privacy and resonal and clinical records, cares, communications, and the right to respectfulness and to their medical and personal case discussion was to be agnoses included Parkinson's hagia and weakness.  Iterly MDS indicated R16 was and received scheduled pain 9/29/15 annual MDS indicated ity to talk on the phone in	F 1	64			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION NG		E SURVEY IPLETED
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	MD-D and R16 talk be overheard from throughout the day about R16's osteoa indicating that he wis wabbed and that F the osteoarthritis.  In an interview on 2 Assistant (NA)-A stameet with R16 and room on 2/17/16. Nhad interviewed resprevious nursing ho 483.20(k)(3)(ii) SEF PERSONS/PER CATThe services provided by	ed about R16's care and could the nurses' station and room area. MD-D talked rthritis, pain, and head cold, ould have R16's throat R16's hip pain was likely due to 1/18/16, at 1:36 p.m., Nursing ated that she did hear MD-A another resident in the day IA-A also stated that MD-A idents in the day room on me rounds.	F 16			3/17/16
	by: Based on observat review, the facility fa and toileting service for 1 of 3 residents ulcers and urinary in Findings include: R18's Diagnosis Su indicated R18's diag mental status, weak	mmary list dated 12/22/15, gnoses included altered		F282: It is the policy and practice of the Cornel Hospital and Care Center that the residents comprehensive care pland repositioning and toileting policies be followed as written.  DON immediately re-educated all notates and the staff on 2/19/16 regarding the follow policies: Comprehensive Nursing policies: Comprehensive Nursing policies: Comprehensive Nursing policies: A mandatory meeting will be held by the staff on 2/14/14.	ursing ving olicy 06);	

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
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F 282	and was usually ab had short and long severely impaired of was frequently incorporated and side and side and side, move from standing and transfistaff to assist R18 to the Impaired Bladd reviewed on 2/17/16 bladder incontinent to the toilet.  The undated nursing p.m. toileting group reposition R18 even the toilet every one  A Care Center Resisted the toilet every one  A Care Center Resisted the toilet every one  A Care Center Resisted dated 2/17/16 repositioned every one controlleting were off R18 was observed from the nurses starecliner with her feet and side and should be supported by the second should be supported by the supported by the second should be supported by the sec	R18 was usually understood le to understand others. R18 term memory problems and lecision making skills. R18 Intinent of bowel and bladder. pressure ulcers and had devices on the bed and chair.  Aired Skin Integrity care plan 6, indicated R18 was at risk 8 had an alternating pressure less on the bed and used a Dry ion (Roho) in the chair. The eplan reviewed on 2/17/16, impaired ability to turn side to anding to sitting, sitting to lers. The care plan directed or reposition every one hour. Her Elimination care plan 6 indicated R18 had frequent lee and was unable to transfer g assistant (NA) a.m. and sheet directed staff to ry one hour and assist R18 to and a half hours.  Ident Care Plan Summary 6, directed R18 was to be	F 2	82	DON on 3/16/16 and 3/17/16 for all nursing personnel/activity staff and restorative nursing to re-educate or above named policies.  All new employees are currently edithrough new employee orientation.  A QAPI was developed on 3/8/16 to compliance and ongoing monitoring nursing personnel with toileting and repositioning of residents -following individualized comprehensive care DON, MDS Coordinator and/or chanurse will complete this through dire observation.  R18 care plan related to repositionitoileting was reviewed immediately DON and MDS Coordinator. All nur personnel were re-educated as to holieting and repositioning is provided one hour and toileting is provided one hour and toileting is provided one and one-half hour. Staff were a re-educated that R18 is to have her ROHO cushion in her chair of choic times to aide in preventing breakdo and to relieve pressure. Audits will be performed on a regular basis by the MDS Coordinator and/or staff nurse insure compliance with R18 carepla.  To prevent similar occurences in the future all residents will be audited a the QAPI indicated above to insure compliance with their individualized plan related to toileting and reposition as stated this will be performed by the stated the s	the ucated insure g of their plan. rge ect ing and by sing er to every very lso e at all wn be DON, e to in.	

	FOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY IPLETED
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F 282	Roho cushion. R18 a.m. when nursing R18 and R18 refusion NA-A to try. NA-A a ambulate to R18's is were observed with buttock were red ar wet with urine. After NA-A applied a barron On 2/18/16, at 9:35 toileted and placed NA-B stated R18 whour and toileted even NA-B verified the gray hour repositioning a toileting. NA-B stated directed.  On 2/19/16, from 8: was observed in the the Roho cushion on R18's buttocks were a darmeasured 9 by 13 compared was blanchable. The On 2/19/16, at 9:25 to be repositioned every one and a haltoileting group sheed Resident Care Plan summarization of the The facility's Care Policy revised on 12 must be followed at the reference of the summarization of the reposition of the reposition of the resident Care Plan summarization of the reposition of the reposition of the resident Care Plan summarization of the reposition of the reposition of the resident Care Plan summarization of the resid	remained this way until 9:10 assistant (NA)-B approached ed to get up. NA-B then asked ssisted R18 to stand and bathroom. R18's buttocks NA-A. NA-A verified R18's and the incontinent product was reproviding incontinence care rier cream to R18's buttocks.  a.m. NA-B stated R18 was in the recliner at 7:00 a.m. as to be repositioned every very one and a half hours. roup sheet directed every one and every one and a half hour ed this had not been done as  30 a.m. until 8:50 a.m. R18 e main dining room sitting on a dining chair. At 8:50 a.m. e observed with registered RN-B. RN-A verified R18's ek red color. The area sentimeters (cm) and the area dere were no open areas.  a.m. RN-B verified R18 was every one hour and toileted lif hours. The RN stated the et and the Care Center Summary sheet were a	F 2	282	DON, MDS Coordinator and/or chanurse through direct observation at		

PRINTED: 03/10/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

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F 282 F 314 SS=D	resident showed signepositioning the repositioning the repositioned every oneeded. The facility revised on 7/8/14, in policy was to ensure safely on a routine laccording to their in 483.25(c) TREATM PREVENT/HEAL Plassed on the compresident, the facility who enters the facil does not develop prindividual's clinical of they were unavoidal pressure sores recesservices to promote prevent new sores for the side of the sores for the side of	gns of redness before two hour sident would then be one hour or more often as its Toileting Residents policy indicated the purpose of the eresidents were toileted pasis in a timely manner dividualized care plan.  ENT/SVCS TO RESSURE SORES  rehensive assessment of a must ensure that a resident ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and healing, prevent infection and	F 2				3/17/16
	by: Based on observat review, the facility fa services were provious who was at risk for Findings include: R18's Diagnosis Su indicated R18's diagnental status, weak A Tissue Tolerance determine the ability	ion, interview and document ailed to ensure care and ded for 1 of 3 residents R18 pressure ulcers.  mmary list dated 12/22/15, gnoses included altered and edema.  Assessment (a tool used to			F314: It is the policy of the Cook Hospital at Care Center to follow each residents individualized care plan as well as the facility Repositioning and Skin Assessment policies.  DON immediately re-educated all nustaff on 2-19-16 regarding the expectations and following policies: Comprehensive Care plan, Repositionand Skin Assessment.  A mandatory meeting will be held by	s ne ursing oning,	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		E SURVEY PLETED
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F 314	pressure without ac indicated R18 had phistory of skin issue assessment indicate one hour in bed wit concern or irritation chair to assess for R18's Skin Risk Assindicated R18 was to poor intake and fR18 current weight the bed or sat in the R18 had a history occeyx and ear. R1 tore easily.  The annual Minimu 1/22/16, indicated F was usually able to short and long term severely impaired oneeded the extensibed mobility and trapressure ulcers and devices on the bed.  The Pressure Ulcer (CAA) dated 1/29/1 for skin breakdown incontinence, poor refusals to reposition with thin skin over the attempted to reposition also would frequent recliner at night white a long period of times.	liverse effects) dated 4/8/15, pressure ulcers and had a person and had a	F 3	314	DON with all nursing, activities and restorative staff on 3/16/16 and 3/1 for a full re-education of the importation following the Comprehensive Care Repositioning and Skin Assessment policies.  New employees will receive educative regarding said policies during new employee orientation.  A QAPI was created by the DON or 3/8/16 to insure compliance and on monitoring through direct observative audits regarding toileting, skin assessments and repositioning of residents. The DON, MDS Coordinational and/or charge nurse will perform the ongoing audits.  R18's Plan of care was reviewed by and MDS Coordinator. Staff will prorepositioning every one hour as directleted to her skin risk assessment tissue tolerance assessment. Staff immediately re-educated on R18 Coplan related to repositioning need one hour.  The QAPI noted above will include of all current and future residents we performed by DON and/or MDS Coordinator and Charge nurse through direct observation based on individuation care plans related to repositioning residents in the plant of the positioning related to repositioning re	7/16 ance of plan, of tion cion ator e y DON ovide ected and were are of every audits vill be ugh ualized	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING			E SURVEY PLETED
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F 314	reviewed on 2/17/16 for breakdown. The gentle care with car tears to the skin. Raredistribution mattre Floatation Air Cushi Mobility Deficit care indicated R18 had i side, move from stastanding and transfestaff to assist R18 to The undated nursin p.m. toileting group reposition R18 ever the toilet every one  A Care Center Resisheet dated 2/17/16 cushion on the chait the bed and staff to The Daily Skin Care from 12/21/15 throubuttocks were red. I left open to air. On was applied and on Tegaderm with paddressing used to pro The daily document of the skin condition On 2/18/16, R18 wa 7:10 a.m. to 9:10 a.i. offered or provided. observed in the unit nurses station. R18 her feet elevated. R	65, indicated R18 was at risk care plan directed staff to use the stage of the easy bruising and all had an alternating pressure the easy on the bed and used a Dry on (Roho) in the chair. The plan reviewed on 2/17/16, impaired ability to turn side to and ing to sitting, sitting to ers. The care plan directed to reposition every one hour.  If a sasistant (NA) a.m. and sheet directed staff to y one hour and assist R18 to and a half hours.  If a care Plan Summary is identified R18 had a Roho or, a redistribution mattress on reposition every hour.  If a Documentation reviewed gh 2/19/16, indicated R18's Most days the buttocks were 12/24/15, an enzymatic paste 1/20/16 through 1/27/16, a (a transparent waterproof otect wounds) was applied. ation lacked an assessment	F 3	314			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		CONSTRUCTION		E SURVEY IPLETED
		245392	B. WING			02/	19/2016
	PROVIDER OR SUPPLIER  OMMUNITY HOSPITA	L C&NC		10	REET ADDRESS, CITY, STATE, ZIP CODE SOUTHEAST FIFTH STREET OOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	9:10 a.m. when nur approached R18 ar NA-B asked NA-A t assisted R18 to sta bathroom. R18's but NA-A. NA-A verified R18's incontinent p After providing incobarrier cream to R1 On 2/18/16, at 9:35 put on the recliner a R18 was to be repotoileted every one averified the group s repositioning and everified the group s repositioning and everified the R0-but ocushion on R18's buttocks were nurse (RN)-A and Fouttocks were a dameasured 9 by 13 cwas blanchable. The On 2/19/16, at 9:25 to be repositioned every one and a hat toileting group sheer Resident Care Plansummarization of the Daily Skin Care Dobuttocks were doculacked assessment	sing assistant (NA)-B and R18 refused to get up. o attempt to get R18 up. NA-A and and ambulate to R18's attocks were observed with d R18's buttock were red and roduct was wet with urine. antinence care NA-A applied a 8's buttocks.  a.m. NA-B stated R18 was at 7:00 a.m. The NA stated astitioned every one hour and and a half hours. The NA heet directed every one hour very one and a half hour arified this had not been done  30 a.m. until 8:50 a.m. R18 be main dining room sitting on an a dining chair. At 8:50 a.m. be observed with registered and and the area been timeters (cm) and the area been were no open areas.  a.m. RN-B verified R18 was been were no open areas.  a.m. RN-B verified R18 was been were no open areas.  a.m. RN-B verified R18 was been were no open areas.  a.m. RN-B verified R18 was been were no open areas.  a.m. RN-B verified R18 was been were no open areas.  a.m. RN-B verified R18 was been were no open areas.  a.m. RN-B verified R18 was been were and toileted and the Care Center and the Care Center and the Care Center and the RN-B verified the cumentation indicated R18's and the RN-B verified R18's and the RN-B verified the cumentation indicated R18's and the RN-B verified	F3	314			

	F CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED
		245392	B. WING		02/1	19/2016
	PROVIDER OR SUPPLIER  OMMUNITY HOSPITA	L C&NC		STREET ADDRESS, CITY, STATE, ZIP CODE  10 SOUTHEAST FIFTH STREET  COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO ( (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 11	F 3	14		
F 315 SS=D	indicated a Tissue Tobe done on all reside independently in the showed signs of recrepositioning the residended.  The facility's Skin As 6/28/06, indicated a measured and docu 483.25(d) NO CATHRESTORE BLADDED Based on the resident who enters indwelling catheter is resident's clinical cocatheterization was who is incontinent of treatment and service.	HETER, PREVENT UTI, ER ent's comprehensive cility must ensure that a the facility without an s not catheterized unless the condition demonstrates that necessary; and a resident f bladder receives appropriate ces to prevent urinary tract store as much normal bladder	F 3	15		3/17/16
	by: Based on observative review, the facility facare and services were sidents R18 review. Findings include:	IT is not met as evidenced ion, interview and document ailed to ensure incontinence were provided for 1 of 3 wed for urinary incontinence.		F315: It is the policy of the Cook Hospital Care Center that employees follow residents individualized care plan vincludes toileting; and Comprehens Care plan.  DON immediately provided a re-ed	a vhich sive	
	Trio a Diagnosia ou	mmary not dated 12/22/10,		DOM IMMIGRICATOR PROVIDED A 10-64	GOGGOTT	

PRINTED: 03/10/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION		E SURVEY PLETED
		245392	B. WING			02 <i>l</i> ′	19/2016
	PROVIDER OR SUPPLIER  OMMUNITY HOSPITA	AL C&NC		10	REET ADDRESS, CITY, STATE, ZIP CODE DISOUTHEAST FIFTH STREET OOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	The annual Minimum 1/22/16, indicated I was usually able to short and long term severely impaired on needed the extensitoileting and person frequently incontine (CAA) dated 1/29/16 frequently incontine assistance of one seneeds. R18 was to half hours, as needs oiled due to frequently incontine assistance of one seneeds. R18 was to half hours, as needs oiled due to frequently incontined to the toilet.  The Impaired Bladd reviewed on 2/17/16 bladder incontinent to the toilet.  The undated nursing p.m. toileting group R18 to the toilet evioleting group sheef frequently incontined A Care Center Research and the bathroom unatter the state of the state of the bathroom unatter the sheet dated 2/17/16 the bathroom unatter the state of the state	ignoses included altered kness and edema.  Im Data Set (MDS) dated R18 usually understood and understand others. R18 had memory problems and decision making skills. R18 ive assistance of one staff with hal hygiene. R18 was ent of bowel and bladder.  Inence Care Area Assessment 16, indicated R18 was ent of urine and required the staff to complete toileting be toileted every one and a led, and when requested or ent incontinence and fragile  der Elimination care plan 6 indicated R18 had frequent ce and was unable to transfer one assistant (NA) a.m. and o sheet directed staff to assist ery one and a half hours. The est further indicated R18 was ent of urine.  ident Care Plan Summary 6, directed R18 may be left in lended.	F3	115	on 2/19/16 to the nursing department insure that the individualized care pand toileting plans are followed as an and toileting plans are followed as a substant of the comprehensive of the Comprehensive Care plan including the toileting policy and following the individualized care plans and toileting group sheets.  All new employees will be educated their new employee orientation.  A QAPI was created by the DON or 3/8/16 to insure compliance and on monitoring with the residents individualized care plan including the toileting plan. DON, MDS Coordina and/or charge nurses will audit through the direct observation as well as verificated that the residents specific toileting generated as written.  R18 Care plan was reviewed by the and MDS Coordinator. All staff were re-educated immediately on reside individualized care plan regarding in need for toileting every one and one hours and as needed. Resident will toileted at every one and one-half hand as needed.  The QAPI noted above includes on monitoring and compliance for individualized toileting plans accompliance accomplia	plan written.  y DON te all taff on tiding pir ng d during tor, ugh ation group e DON e nts ter e-half be tours going plished	
	7:10 a.m. to 9:10 a	as continuously observed from .m. and toileting was not . At 7:10 a.m. R18 was			through direct observation audits for current and future residents. These will be performed by the DON, MDS	audits	

Facility ID: 00586

PRINTED: 03/10/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF CORRECTION	IDENTIFICATION NUMBER:	` '				IPLETED
		245392	B. WING			02/	19/2016
	PROVIDER OR SUPPLIER  OMMUNITY HOSPITA	L C&NC		1	TREET ADDRESS, CITY, STATE, ZIP CODE 0 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	observed in the uninurses station. R18 a.m. when nursing R18 and R18 refus NA-A to attempt to R18 to stand and a NA-A verified R18's incontinent product providing incontinent barrier cream to R1  On 2/18/16, at 9:35 toileted and then pundated and then pundated and then pundated and then pundated and the pundate	t living room across from the remained there until 9:10 assistant (NA)-B approached ed to get up. NA-B asked get R18 up. NA-A assisted mbulate to R18's bathroom. buttock were red and R18's was wet with urine. After nce care NA-A applied a	F3	315	Coordinator and/or charge nurse.		

PRINTED: 03/11/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A: BUILDING 01 - MAIN BUILDING 01 245392 B. WING 02/17/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTHEAST FIFTH STREET **COOK COMMUNITY HOSPITAL C&NC** COOK, MN 55723 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 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: LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE

TITLE

**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.

CENTER	RS FOR MEDICAR	E & MEDICAID SERVICES			OMB MC	0. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01		TE SURVEY MPLETED
		245392	B. WING		02	/17/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 10 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
K 000	Continued From p Marian.Whitney@ or Angela.Kappenma	state.mn.us an@state.mn.us	K	000		
		ORRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION:				
;	A description of what has been, o to correct the deficiency.					
	2. The actual, or p	proposed, completion date.				
	3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.					
	partial basement. constructed in 196 and 2005 The ori additions are all T therefore, the facili building. The facili	R NC is a 1-story building with a The original building was 60 with additions in 1966, 2000, ginal building buildings and ype II (111) construction, lity was inspected as one ity has a clinic, hospital and an g that are properly separated nome.				
	facility has a comp smoke detection i	ly fire sprinkler protected The plete fire alarm system with n spaces open to the corridor, for automatic fire department				
		licensed capacity of 28 beds of 27 at the time of the survey.				,
	The requirement a	at 42 CFR, Subpart 485.623 (d)				

NAME OF PROVIDER OR SUPPLIER  COOK COMMUNITY HOSPITAL C&NC  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  K 000  Continued From page 2 is NOT MET.  K 025  NFPA 101 LIFE SAFETY CODE STANDARD  SSSEE  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.	(X3) DATE SURVEY COMPLETED	
COOK COMMUNITY HOSPITAL C&NC  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  K 000 Continued From page 2 is NOT MET.  K 025 NFPA 101 LIFE SAFETY CODE STANDARD  SS=E  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.	02/17/	7/2016
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  K 000  Continued From page 2 is NOT MET.  K 025  SS=E  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.		
is NOT MET.  K 025  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.	BE C	(X5) COMPLETION DATE
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	cal pening barrier he 6 eiling ited by	2/29/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01			E SURVEY PLETED	
		245392	B. WING		02/	17/2016	
NAME OF PROVIDER OR SUPPLIER COOK COMMUNITY HOSPITAL C&NC			1	STREET ADDRESS, CITY, STATE, ZIP CODE  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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLI		
K 029 SS=D	One hour fire rated fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro the approved autor option is used, the other spaces by sr doors. Doors are sield-applied proted 48 inches from the permitted. 19.3.7 This STANDARD Based on observarevealed that the faproper protection fareas located throughout areas making then negatively affect the staff and visitors.  Findings include:  On facility tour betwoeld 17/2016, observertical penetration a horizontal penetration.	AFETY CODE STANDARD  d construction (with o hour or an approved automatic fire em in accordance with 8.4.1 beets hazardous areas. When matic fire extinguishing system areas are separated from moke resisting partitions and self-closing and non-rated or citive plates that do not exceed bottom of the door are 2.1 is not met as evidenced by: ations and staff interview, it was acility has failed to provide for 1 of several hazardous ughout the facility in FPA Life Safety Code 101 (00) This deficient conditions could be, allow smoke and flames to the effected corridors and on untenable, which could be exiting capabilities residents, ween 11:00 AM to 3:00 PM on vation revealed that there is a or around the hydraulic pipe and retation around the fire sprinkler and within the elevator	K 029	K29: The vertical penetration around hydraulic pipe and a horizont around the fire sprinkler pipe within the elevator control/moroom have been patched/repsealant was applied.	tal penetration located echanical	2/29/16	
K 050 SS=D	Maintenance Supe	lition was verified by a	K 050			3/21/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245392			02/17/2016		
NAME OF PROVIDER OR SUPPLIER  COOK COMMUNITY HOSPITAL C&NC			STREET ADDRESS, CITY, STATE, ZIP CODE  10 SOUTHEAST FIFTH STREET  COOK, MN 55723				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	UST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		OULD BE	(X5) COMPLETION DATE	
K 050	signal and simulatic conditions. Fire drill times under varying on each shift. The and is aware that droutine. Responsib conducting drills is persons who are quality where drills are co 6:00 AM a coded a instead of audible at 18.7.1.2, 19.7.1.2. This STANDARD is Based on review of interview, it was de to conduct fire drills Safety Code 101(0) 12-month period. Taffect how staff real Improper reaction is of 27 of 27 resident. Findings include:  On facility tour betwoeld to complete the facility of 10 affecting the facility 1. The facility could 1 Day shift fire drill 2. The facility could 1 Overnight shift fire quarter.	ne transmission of a fire alarm on of emergency fire als are held at unexpected g conditions, at least quarterly staff is familiar with procedures wills are part of established ility for planning and assigned only to competent utualified to exercise leadership, and anouncement may be used alarms.  Is not met as evidenced by: of reports, records and staff termined that the facility failed in accordance with NFPA Life (a), 19.7.1.2, during the last this deficient practice could act in the event of a fire. By staff would affect the safety the safety with the review of all available fire and interview with the rvisor it was revealed that the twing deficient conditions	K 05	K50: The Plant Manager will review paperwork immediately or as spossible after a fire drill to mak drill was documented and the trills are included on the form.  A QAPI will be developed by 3/2 make sure forms are filled out fire drill and that all forms have required documentation. The Manager will review the forms documentation on a monthly be enter the results each quarter QAPI that corresponds with this	oon as e sure the imes of the  21/16 to during a all Plant and asis and on the		

ATEMENT				D. E. G. C.	(VO) DAT	E CHOVEY	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245392			(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		B. WING		02/	17/2016		
	PROVIDER OR SUPPLIER  OMMUNITY HOSPITA	L C&NC		STREET ADDRESS, CITY, STATE, ZIP C 10 SOUTHEAST FIFTH STREET COOK, MN 55723			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
K 050	quarter.	drill in the 3rd calendar ition was verified by a	K 05	0	(E)		
K 052 SS=D	A fire alarm system be, tested, and main NFPA 70 National Fine Alarm available. The system aintenance and to applicable requirem 9.6.1.4, 9.6.1.7, This STANDARD is Based on observate facility failed to instruct system in accordar 2000 NFPA 101, Sections 7.1. The adversely affect the system that could be emergency actions affecting 27 of 27 rethe facility.  Findings include:  On facility tour betw 02/17/2016, observative of all available.	required for life safety shall intained in accordance with electric Code and NFPA 72. Code and records kept readily em shall have an approved esting program complying with nent of NFPA 70 and 72.  Is not met as evidenced by: tion and staff interview, the all and maintain the fire alarmine with the requirements of ections 19.3.4., 19.3.6.3.2, as well as 1999 NFPA 72, as deficient practices could be functioning of the fire alarmine for the facility thus negatively esidents, staff, and visitors of extension revealed that during the old fire drill reports and fire extension documentation for the	K 05	K52: The Plant Manager will revipaperwork immediately or a possible after each fire drill the confirmation from WH Fithe DACT Test and the name employee that has conduct has been documented on the report form.  A QAPI will be developed be Plant Manager will audit all forms for the documentation Response for the DACT Tedocumentation of the name employee that conducted the The Plant Manager will audit and the plant Manager will and the plant Manager will and the plant Manager will audit and the plant Manager will and the plant Manager w	as soon as to make sure Response for ne of the ed the fire drill ne fire drill  y 3/21/16. The fire drill report n of the WH st and e of the ne fire drill. it forms	3/21/16	
	National Fire Alarmavailable. The systemaintenance and to applicable requirem 9.6.1.4, 9.6.1.7, This STANDARD is Based on observate facility failed to instruct system in accordar 2000 NFPA 101, Sections 7.1. The sadversely affect the system that could demergency actions affecting 27 of 27 rethe facility.  Findings include:  On facility tour betwo 2/17/2016, observative of all availate alarm maintenance last 12 months and Maintenance Supe	Code and records kept readily em shall have an approved esting program complying with nent of NFPA 70 and 72.  Is not met as evidenced by: tion and staff interview, the all and maintain the fire alarm nee with the requirements of ections 19.3.4., 19.3.6.3.2, as well as 1999 NFPA 72, se deficient practices could efunctioning of the fire alarm delay the timely notification and for the facility thus negatively esidents, staff, and visitors of even 11:00 AM to 3:00 PM on vations revealed that during the	,	The Plant Manager will revipaperwork immediately or a possible after each fire drill the confirmation from WH F the DACT Test and the namemployee that has conduct has been documented on the report form.  A QAPI will be developed be Plant Manager will audit all forms for the documentation Response for the DACT Tedocumentation of the name employee that conducted the possible page 1.	as soon as to make sure Response for ne of the ed the fire dr ne fire drill  y 3/21/16. T fire drill repo n of the WH st and e of the ne fire drill. it forms results on th	ill he	

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

PRINTED: 03/11/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 245392 B WING 02/17/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTHEAST FIFTH STREET **COOK COMMUNITY HOSPITAL C&NC** COOK, MN 55723 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 052 | Continued From page 6 K 052 This deficient condition was verified by a Maintenance Supervisor. 3/25/16 K 054 NFPA 101 LIFE SAFETY CODE STANDARD K 054 SS=D All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. This STANDARD is not met as evidenced by: Based on staff interview and a review of the K54: The Plant Manager will be scheduling available documentation, the facility has not Nardini to perform the required sensitivity conducted that required sensitivity testing of the testing of the smoke detectors on the fire smoke detectors on the fire alarm system in alarm system. This will be scheduled by accordance with NFPA 72 National Fire Alarm 3/25/16. The Plant Manager has placed a Code (99), Sec. 7-3.2.1. This deficient practice could affect 27 of 27 residents, visitors, and staff. reminder on his outlook calendar for the two year reminder. 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. 3/3/16 K 062 NFPA 101 LIFE SAFETY CODE STANDARD K 062 SS=D Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested

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

PRINTED: 03/11/2016 FORM APPROVED OMB NO. 0938-0391

			E SURVEY IPLETED			
		245392	B. WING_		02/	17/2016
	PROVIDER OR SUPPLIER  OMMUNITY HOSPITA	L C&NC		STREET ADDRESS, CITY, STATE, ZIP CODE 10 SOUTHEAST FIFTH STREET COOK, MN 55723		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 062	9.7.5 This STANDARD is Based on docume with staff, the facility and maintain the at accordance with Ni Section 19.7.6, and of Sprinkler System for the Inspection, Water Based Fire Edeficient practice disprinkler system is fully operational in negatively affect 27 visitors.  Findings include:  On facility tour betw 02/17/2016, a revisitors with the limiter with the limiter with the limiter with staff and the staff and t	age 7 7.6, 4.6.12, NFPA 13, NFPA 25, s not met as evidenced by: ntation review and interview by has failed to properly inspect utomatic sprinkler system in FPA 101 Life Safety Code (00), 4.6.12, NFPA 13 Installation ins (99), and NFPA 25 Standard Testing and Maintenance of Protection Systems, (98). This oes not ensure that the fire functioning properly and is the event of a fire and could of 27 residents, staff and ween 11:00 AM to 3:00 PM on the world occumentation and Maintenance Supervisor at time of the inspection the	K 06	K62: We have elected to use the Cate Waiver for Extinguishing Require copy of this waiver is attached. The Plant Manager will be condisemi-annual fire sprinkler flow to	ements. Aucting	
K 072 SS=D	facility could not proof 4 quarterly fire s completed.  This deficient cond Maintenance Supe NFPA 101 LIFE SAME Means of egress siftee of all obstructionstant use in the construct exits, according to the contract of the contract of the contract exits, according to the contract exits and the contract exits	ovide any documentation for 1 prinkler flow test having been lition was verified by a rvisor.  AFETY CODE STANDARD hall be continuously maintained ons or impediments to full ase of fire or other emergency corations, or other objects shall ess thereto, egress there from, shall be in accordance with	K 07	22		3/14/16

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00586

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

PRINTED: 03/11/2016 FORM APPROVED OMB NO. 0938-0391

CEIVIE	13 I OK WEDICAKE	& MEDICAID SERVICES			CIVID NO.	0930-038	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG <b>01 - MAIN BUILDING 01</b>		(X3) DATE SURVEY COMPLETED	
		245392	B. WING _		02/	17/2016	
	PROVIDER OR SUPPLIER	L C&NC		STREET ADDRESS, CITY, STATE, ZIP CODE  10 SOUTHEAST FIFTH STREET  COOK, MN 55723		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPOPER DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 072	the means of egree obstructions or imp the case of fire or accordance with N (2000 edition) Challobstructions could and effective removisitors in an emergence obstruction of the country of the country of the country of the case of the	age 8 tions the facility failed to keep as continuous and free of all rediments to full instant use in other emergency, in FPA Life Safety Code 101 oter 7, Section 7.1.10. These interfere with the convenient wal all residents, staff and gency situation, and impede ons during a fire emergency.	K 07	K72: The Plant Manager has moved into the Adult Day Stay area so no longer in the hallway. The comachine will be moved out of the on 3/14/16 when the IT Directors.	they are copy he hallway	A	
	02/17/2016 during that there are chair Adult Day Service and there is a copie obstructing the san	ition was verified by a					
K 075 SS=D	Soiled linen or tras exceed 32 gal (121 density of containe does not exceed .5 capacity of 32 gal (any 64 sq ft (5.9-so or trash collection r greater than 32 gal protected as a hazattended. 19.7.5 This STANDARD is	h collection receptacles do not L) in capacity. The average r capacity in a room or space gal/sq ft (20.4 L/sq m). A 121 L) is not exceeded within m) area. Mobile soiled linen receptacles with capacities (121 L) are located in a room ardous area when not 5 s not met as evidenced by:	K 07	K75:	æ	3/11/16	
	Based on observa facility has failed to	tions and staff interview, the store large trash and linen otected rooms in accordance		K75: The multiple binned mobile soi containers that are larger than			

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

PRINTED: 03/11/2016 FORM APPROVED OMB NO. 0938-0391

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245392	B. WING		02/	17/2016	
				STREET ADDRESS, CITY, STATE, ZIP C 10 SOUTHEAST FIFTH STREET COOK, MN 55723			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
K 075	OF CORRECTION IDENTIFICATION NUMBER:	"The Life Safety Code" 2000 on 19.7.5.5. This deficient of the safety of all residents, smoke or fire from one of ed the corridors untenable.  Ween 11:00 AM to 3:00 PM on found in that the facility was ned mobile solid linen an aggregate capacity that is llons being stored in the m room 108, and not in the s storage areas.	K 07	gallon aggregate capacity a the hazardous storage area removed when the new rece arrive.  Smaller capacity soiled liner collection receptacles will be 3/11/16. One receptacle wil for each of the two hallways above, when these arrive th will be removed from use.	and will be eptacles  n/trash e ordered by I be ordered . As stated		



#### 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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

Cook Community Hospital C & NC March 2, 2016 Page 2

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

(X6) DATE

Minnesota Department of Health

	AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00586	B. WING		02/19/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	L C&NC 10 SOUTI	HEAST FIFTI N 55723	H STREET		
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2 000	2 000 Initial Comments					
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficit herein are not corrected shall I with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota MN Rumber and MN Rumber and MN Rumber and may of the comply with any of the lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 03/08/16

TITLE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SU IDENTIFICATION		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00586		B. WING		02/	19/2016
	PROVIDER OR SUPPLIER  OMMUNITY HOSPITA	L C&NC		HEAST FIFTI	STATE, ZIP CODE H STREET		
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2 000	Continued From particles of the angular part of Heary you electronically. It is necessary for State enter the word "context. You must then State licensure procompletion date, the corrected prior to element of the Minnesota Department's sand the following context. When corrections a date, make a copy original to the Minnesota Department's sand the following context of the Minnesota Department's sand the following context of the Minnesota Department of the Minnesota Department of the State Licensing federal software. The assigned to Minnesonal Minnesota Department of the State Licensing federal software. The assigned to Minnesonal Minnesota Department of the State Licensing federal software. The assigned to Minnesonal	Ith orders being Although no plan ate Statutes/Rule rected" in the boundicate in the edges, under the edges, under the edges, under the edges, under the edge of Health.  It is 19, 2016, so taff, visited the aborrection orders are completed, por these orders are completed in the edge of	n of correction es, please ox available for electronic heading ers will be mitting to the surveyors of above provider are issued. lease sign and and return the nt of Health, Licensing and erior Street;  documenting ers using e been es/rules for in the far left he state ed in the es" column on of the includes the estate statute of met as ors findings ection and	2 000			
	FOURTH COLUMN						

6899

Minnesota Department of Health STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00500	B. WING		00/4	0/004.0
NAME OF I	PROVIDER OR SUPPLIER	00586	<u>l</u>	STATE, ZIP CODE	02/1	9/2016
		10 SOUTH	HEAST FIFTI			
COOK C	OMMUNITY HOSPITA	COOK, M	N 55723			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.					
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			3/17/16
		omprehensive plan of care I personnel involved in the t.				
	by: Based on observati review, the facility f and toileting service	ent is not met as evidenced ion, interview and document ailed to provide repositioning es as directed by the care plan (R18) reviewed for pressure ncontinence.		CORRECTED		
	Findings include:					
		ummary list dated 12/22/15, gnoses included altered kness and edema.				
	1/22/16, indicated F and was usually ab had short and long severely impaired of was frequently inco	m Data Set (MDS) dated R18 was usually understood le to understand others. R18 term memory problems and lecision making skills. R18 ntinent of bowel and bladder. pressure ulcers and had				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00586	B. WING		02/1	9/2016
_	PROVIDER OR SUPPLIER  OMMUNITY HOSPITA	10 SOUTH	DRESS, CITY, S	STATE, ZIP CODE		
COOK C	OMMUNITY HOSPITA	COOK, MI	N 55723			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	pressure reduction R18's Risk for Impareviewed on 2/17/1/ for breakdown. R18 redistribution mattre Floatation Air Cush Mobility Deficit care indicated R18 had is side, move from sta standing and transf staff to assist R18 t The Impaired Bladd reviewed on 2/17/1/ bladder incontinend to the toilet.  The undated nursin p.m. toileting group reposition R18 ever the toilet every one A Care Center Resi sheet dated 2/17/16 repositioned every On 2/18/16, R18 wa 7:10 a.m. to 9:10 a. or toileting were off R18 was observed from the nurses sta	devices on the bed and chair.  aired Skin Integrity care plan 6, indicated R18 was at risk 8 had an alternating pressure ess on the bed and used a Dry ion (Roho) in the chair. The e plan reviewed on 2/17/16, mpaired ability to turn side to anding to sitting, sitting to ers. The care plan directed o reposition every one hour. der Elimination care plan 6 indicated R18 had frequent re and was unable to transfer re and was unable to transfer re and a half hours. dent Care Plan Summary 6, directed R18 was to be one hour. as continuously observed from am. and neither repositioning ered or provided. At 7:10 a.m. in the unit living room across ation. R18 was sitting in a	2 565	DEFICIENCY)		
	directly on the seat Roho cushion. R18 a.m. when nursing R18 and R18 refus NA-A to try. NA-A a ambulate to R18's b were observed with	et elevated. R18 was sitting of the recliner without the remained this way until 9:10 assistant (NA)-B approached ed to get up. NA-B then asked ssisted R18 to stand and pathroom. R18's buttocks NA-A. NA-A verified R18's and the incontinent product was				

Minnesota Department of Health

STATE FORM 6899 616J11 If continuation sheet 4 of 17

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00586	B. WING		02/1	9/2016
	PROVIDER OR SUPPLIER	10 SOUTH	DRESS, CITY, S	STATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	L C&NC COOK, MI				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 4	2 565			
	On 2/18/16, at 9:35 toileted and placed NA-B stated R18 w hour and toileted ex NA-B verified the gr	r providing incontinence care rier cream to R18's buttocks.  a.m. NA-B stated R18 was in the recliner at 7:00 a.m. as to be repositioned every very one and a half hours. roup sheet directed every one and every one and a half hour				
		ed this had not been done as				
	was observed in the the Roho cushion of R18's buttocks wer nurse (RN)-A and F buttocks were a da measured 9 by 13 of	30 a.m. until 8:50 a.m. R18 e main dining room sitting on a dining chair. At 8:50 a.m. e observed with registered RN-B. RN-A verified R18's rk red color. The area centimeters (cm) and the area ere were no open areas.				
	to be repositioned e every one and a ha toileting group shee	a.m. RN-B verified R18 was every one hour and toileted If hours. The RN stated the et and the Care Center Summary sheet were a ne care plan.				
	policy revised on 12 must be followed at Repositioning policy resident showed sign repositioning the repositioned every needed. The facility revised on 7/8/14, i policy was to ensur safely on a routine	Plan Comprehensive-Nursing 2/14, indicated the care plan all times. The facility's y dated 6/26/06, indicated if a gns of redness before two hour sident would then be one hour or more often as r's Toileting Residents policy indicated the purpose of the e residents were toileted basis in a timely manner adividualized care plan.				

Minnesota Department of Health

STATE FORM 6899 616J11 If continuation sheet 5 of 17

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

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			A. BOILDING.			
	00586		B. WING		02/	19/2016
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OMMUNITY HOSPITA	L C&NC			1 STREET		
(EACH DEFICIENCY	MUST BE PREC	EDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE
Continued From pa	ge 5		2 565			
director of nursing (could develop and iresident plans of caimplemented by states designee could edu DON or his/her desprocess to ensure of	(DON) or his/implement sy are are availal aff. The DON acate all appro- ignee could rongoing comp	her designee stems to ensure ble and or his/her opriate staff. The monitor this bliance.				
MN Rule 4658.052	5 Subp. 4 Rel	hab - Positioning	2 905			3/17/16
Subp. 4. Positionin positioned in good of residents unable must be changed a including periods of been put to bed for has documented th hours during this tire.	ng. Residents body alignme to change that least every fime after the hight, unlat repositionine period is	s must be ent. The position eir own position two hours, e resident has less the physician ng every two unnecessary or				
by: Based on observati review, the facility for services were provious who was at risk for Findings include: R18's Diagnosis Suindicated R18's diagnosis	ion, interview ailed to ensur ided for 1 of 3 pressure ulce ummary list da gnoses includ	and document re care and 3 residents R18 ers. ated 12/22/15, ded altered		CORRECTED		
•	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From paragrams  SUGGESTED MET director of nursing of could develop and resident plans of casimplemented by state designee could edu DON or his/her desprocess to ensure of the could days.  MN Rule 4658.0528  Subp. 4. Positioning positioned in good of residents unable must be changed as including periods of been put to bed for has documented the hours during this tirthe physician has of the physician has of the could be the could be the physician has of the physician has of the could be the could be the physician has of the physician has of the physician has of the could be the could be the physician has of the physi	ODS86 PROVIDER OR SUPPLIER  DMMUNITY HOSPITAL C&NC  SUMMARY STATEMENT OF DEF (EACH DEFICIENCY MUST BE PREC REGULATORY OR LSC IDENTIFYING  Continued From page 5  SUGGESTED METHOD OF CO director of nursing (DON) or his/could develop and implement sy resident plans of care are availa implemented by staff. The DON designee could educate all approponents to ensure ongoing components to ensure ongoing components to ensure ongoing components of the process to ensure ongoing components.  MN Rule 4658.0525 Subp. 4 Resulps and the positioned in good body alignments of residents unable to change the must be changed at least every including periods of time after the been put to bed for the night, un has documented that repositioni hours during this time period is the physician has ordered a different by:  Based on observation, interview review, the facility failed to ensure services were provided for 1 of 3 who was at risk for pressure ulcomponents.	OF CORRECTION  O0586  PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.  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.	ODESTIFICATION NUMBER:  ODESTIFICATION  ODESTI	PROVIDER OR SUPPLIER  TOMMUNITY HOSPITAL C&NC  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 5  SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or his/her designee could educate all appropriate staff. The DON or his/her designee could deucate all appropriate staff. The DON or his/her designee could deucate all appropriate staff. The DON or his/her designee could deucate all appropriate staff. The DON or his/her designee could between the process to ensure ongoing compliance.  TIME PERIOD FOR CORRECTION: Twenty-one (21) days.  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	ODSAGE  ROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  10 SOUTHEAST FIFTH STREET  COOK, MN 55723  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC. DENTIFYING INFORMATION)  CONTINUED FOR DATE OF THE APPROPRIATE  CHOOSE REFERENCE TO THE APPROPRIATE  CHOOSE REFERENCE TO THE APPROPRIATE  CHOOSE REFERENCE TO THE APPROPRIATE  DEFICIENCY  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.  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

Minnesota Department of Health STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SU IDENTIFICATIO		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SU COMPLE	
		00586		B. WING		02/	19/2016
	PROVIDER OR SUPPLIER  OMMUNITY HOSPITA	L C&NC		HEAST FIFTI	STATE, ZIP CODE H STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIE 'MUST BE PRECEDE SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 905	Continued From particles and the supporting structure pressure without according to the supporting structure pressure without according to the supporting structure pressure without according to support the support of skin issues assessment indicate one hour in bed with concern or irritation chair to assess for the support of time the support of the support of the support of the support of time the support of time the support of the support of the support of the support of time the support of time the support of time the support of the support of time the support of the support of time the support of	Assessment (a y of the skin and es to endure the dverse effects) doressure ulcers are. The evaluation ed R18 was able to the sessment dated at risk for skin but signs or syntax 75 pounds. A requent supplement	lit's effects of ated 4/8/15, and had a on of the eto tolerate into the eto tolerate int	2 905			

Minnesota Department of Health

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00586		B. WING		02/1	9/2016
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	L C&NC	10 SOUTH COOK, M	HEAST FIFTI N 55723	1 STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN ' MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 905	Continued From pa	ge 7		2 905			
	R18's Risk for Impareviewed on 2/17/16 for breakdown. The gentle care with car tears to the skin. Riredistribution mattre Floatation Air Cushi Mobility Deficit care indicated R18 had i side, move from stastanding and transf staff to assist R18 to the undated nursin p.m. toileting group reposition R18 ever the toilet every one  A Care Center Resisheet dated 2/17/16	6, indicated R18 varieties due to easy branches on the bed and ion (Roho) in the explainment of plan reviewed or impaired ability to anding to sitting, seers. The care planches or eposition every gassistant (NA) as sheet directed standard a half hours.	vas at risk d staff to use ruising and ting pressure d used a Dry chair. The 12/17/16, turn side to itting to 1 directed one hour.  a.m. and aff to ssist R18 to ummary				
	cushion on the chai the bed and staff to	r, a redistribution	mattress on				
	The Daily Skin Care from 12/21/15 throubuttocks were red. left open to air. On was applied and on Tegaderm with pad dressing used to protect the skin condition	igh 2/19/16, indica Most days the but 12/24/15, an enzy 1/20/16 through (a transparent wa otect wounds) wa tation lacked an a	ated R18's tocks were matic paste 1/27/16, a aterproof s applied.				
	On 2/18/16, R18 wa 7:10 a.m. to 9:10 a. offered or provided. observed in the unit nurses station. R18 her feet elevated. R	m. and reposition At 7:10 a.m. R18 t living room acros was sitting in a re	ing was not 3 was ss from the ecliner with				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00586		B. WING		02/1	9/2016
NAME OF	PROVIDER OR SUPPLIER	S	TREET ADD	DRESS, CITY, S	STATE, ZIP CODE	-	
соок с	OMMUNITY HOSPITA	A CXNC	O SOUTH	IEAST FIFTH N 55723	H STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 905	seat of the recliner. 9:10 a.m. when nur approached R18 ar NA-B asked NA-A t assisted R18 to sta bathroom. R18's br NA-A. NA-A verified R18's incontinent p After providing inco barrier cream to R1 On 2/18/16, at 9:35 put on the recliner a R18 was to be repo toileted every one a verified the group s repositioning and e toileting. The NA ve as directed.  On 2/19/16, from 8 was observed in the the Roho cushion of R18's buttocks were nurse (RN)-A and F buttocks were a da measured 9 by 13 of was blanchable. Th  On 2/19/16, at 9:25 to be repositioned of every one and a ha toileting group shee Resident Care Plar summarization of th Daily Skin Care Do buttocks were docu lacked assessment	R18 remained this way raing assistant (NA)-B and R18 refused to get us to attempt to get R18 up and and ambulate to R1 attocks were observed to R18's buttock were reproduct was wet with uring and an experience care NA-A applet's buttocks.  If a.m. NA-B stated R18 at 7:00 a.m. The NA states at 7:00 a.m. The NA states at 7:00 a.m. The NA states are directed every one and a half hour and a half hour. The Nate of the result of the resul	p. c. NA-A 8's with d and ne. plied a  was ated r and A e hour r d done  R18 ng on 0 a.m. ered 8's ne area s. 8 was ated I the a fied the R18's nd urther	2 905			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			71. BOILDING.			
00586		B. WING	·····	02/1	9/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	L C&NC 10 SOUTH	IEAST FIFTI N. 55723	1 STREET		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
2 905	Continued From pa	ge 9	2 905			
2.010	indicated a Tissue be done on all reside independently in the showed signs of recepositioning the repositioned every needed. The facility's Skin A 6/28/06, indicated a measured and door SUGGESTED MET director of nursing could develop and residnet's received prevention based of assessment and places of the process to ensure of the time of the process to ensure of the time of time of the time of time	THOD OF CORRECTION: The (DON) or his/her designee implement systems to ensure pressure ulcer treatment and n a comprehensive an of care. The DON or his/her locate all appropriate staff. The signee could monitor this ongoing compliance.				0/17/16
2 910	MN Rule 4658.0529 Incontinence	5 Subp. 5 A.B Rehab -	2 910			3/17/16
	have a continuous management to recunnecessary use or comprehensive reshome must ensure  A. a resident w without an indwelling	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing that: ho enters a nursing home ag catheter is not catheterized is clinical condition indicates				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00586			B. WING		02/1	9/2016
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
соок с	COOK COMMUNITY HOSPITAL C&NC 10 SOU COOK, I				H STREET		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 910	Continued From parthat catheterization B. a resident whreceives appropriate prevent urinary tracemuch normal bladd	was necessary no is incontinen e treatment and t infections and	t of bladder d services to d to restore as	2 910			
	This MN Requirements by: Based on observation review, the facility for the care and services were sidents R18 reviews	on, interview ar ailed to ensure vere provided fo	nd document incontinence or 1 of 3		CORRECTED		
	Findings include: R18's Diagnosis Suindicated R18's diagnental status, weal The annual Minimu 1/22/16, indicated F was usually able to short and long term severely impaired oneeded the extensitoileting and person frequently incontine	gnoses included kness and eder m Data Set (MIR 18 usually und understand other memory probled in memory probled is assistance of the last hygiene. R18	d altered na.  OS) dated erstood and ers. R18 had ems and skills. R18 one staff with 8 was				
	The Urinary Incontii (CAA) dated 1/29/1 frequently incontine assistance of one s needs. R18 was to half hours, as need soiled due to frequeskin.	6, indicated R1 ent of urine and taff to complete be toileted ever ed, and when re	8 was required the toileting one and a equested or				

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-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	00586		B. WING		02/	19/2016	
			HEAST FIFTH	STATE, ZIP CODE H STREET			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		CIENCIES DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 910	Continued From particles and and an NA-A verified R18's incontinent product providing incontinent particles and and an NA-B stated R18 wand a half hours. To directed every one verified this had not on 2/19/16, at 9:25 on 2/19/	der Elimination 6 indicated R18 de and was una ge assistant (NA) sheet directed ery one and a het further indicatent of urine.  dident Care Plar 6, directed R18 ended.  as continuously m. At 7:10 a.m. Fit living room act in the received R18 de to get up. N. get R18 up. NA mbulate to R18 buttock were in was wet with unce care NA-A 8's buttocks.  dia.m. NA-B state in the recline as to be toilete he NA verified the and a half hour the been done as	A) a.m. and a staff to assist alf hours. The ted R18 was an Summary amay be left in a source of the control of	2 910			
	to be toileted every						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
00586		B. WING		02/1	02/19/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	L C&NC 10 SOUTH	IEAST FIFTI N. 55723	1 STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	Continued From pa	ge 12	2 910			
	policy revised on 12 would describe the furnished to attain a highest practicable psychosocial well be Residents policy repurpose of the policy were toileted safely manner according to plan.	Plan Comprehensive-Nursing 2/14, indicated the care plan services that were to be or maintain the residents physical, mental and eing. The facility's Toileting vised on 7/8/14, indicated the cy was to ensure residents on a routine basis in a timely to their individualized care				
	director of nursing of could develop and residents were toile comprehensive ass. The DON or his/he appropriate staff. To could monitor this prompliance.	DON) or his/her designee mplement systems to ensure				
21855	Residents of HC Fa Subd. 15. Treath residents shall have	ac.Bill of Rights  nent privacy. Patients and the the right to respectfulness lates to their medical and	21855			3/23/16
	personal care progressions personal care progressions consultation, examination confidential and shall be researched.	ram. Case discussion, ination, and treatment are all be conducted discreetly. spected during toileting, activities of personal hygiene,				

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00586	B. WING		02/1	9/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
COOK COMMUNITY HOSPITAL C&NC COOK, M			HEAST FIFTI N 55723	TOINEEL		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21855	Continued From pa	ge 13	21855			
	except as needed f assistance.	or patient or resident safety or				
	by: Based on observati review, the facility for personal status and residents (R28, R10)	ent is not met as evidenced on, interview and document ailed to ensure privacy of d care information for 2 of 2 6) who were observed to have pleted and medical information areas.		CORRECTED		
	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.					
	had an impairment goal was to have be days. R28's care p impaired communic ability to speak and	iated 8/17/15, indicated R28 of bowel elimination and the owel movements every 1-3 lan further indicated R28 had cation due to an impaired a cognitive deficit with the oices 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 observat	ion on 2/18/16, at 8:37 a.m.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			7. DOILDING.					
		00586	B. WING		02/	19/2016		
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE				
соок	OMMUNITY HOSPITA	A CXNC	HEAST FIFTH IN 55723	1 STREET				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE		
21855	registered nurse (F would take pills to h R28 was leaving th and there were 13 staff present in the medication. RN-C I had a bowel mover that they were the I to the bathroom. Fe been 5 days and as take them. R28 comedication, and lef During an interview RN-C verified she his bowel medications, and shim in his room. R information.  During an interview confirmed being as medications in the affirmed it did not be During an interview director of nursing functions and mediabout in the dining in private.  During an observat laboratory technicia culture from R16 w There were several room for activities at technician asked R ask the other reside the resident staff in the staff in	RN)-C loudly asked R28 if he nelp him go to the bathroom. e dining room after breakfast other residents and 6 other dining room. R28 declined the oudly stated that he had not ment for 5 days and explained ittle round pills to help him go RN-C stated again, that it had sked why he did not want to ntinued to decline to take the t the dining room.  If on 2/18/16, at 12:44 p.m. had asked R28 about taking ons while in the dining room. did ask R28 about his tated she could have asked N-C verified it was private  If on 2/18/16, at 1:32 p.m., R28 ked about his bowel dining room, and nonverbally						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00586	B. WING		02/	19/2016
NAME OF	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, S	STATE, ZIP CODE		
соок с	OMMUNITY HOSPITA	A C&NC	UTHEAST FIFTI (, MN 55723	H STREET		
(X4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
21855	Continued From pa	ige 15	21855			
	the area.					
	NA-A stated they us day room, but this t	on 2/17/16, at 10:35 a.m. sually do not do lab work in echnician was new and ow it would be an issue.	the			
	Confidentiality date resident had the rig confidentiality of pe including personal of medical treatments directed, staff will in patients shall have privacy as it relates	nd procedure for Privacy and 6/27/14, indicated the lift to personal privacy and ersonal and clinical records, cares, communications, and in the policy and procedure that residents and the right to respectfulness at to their medical and person case discussion was to be	I			
		agnoses included Parkinsor hagia and weakness.	n's			
	cognitively intact ar medications. R16's	terly MDS indicated R16 wand received scheduled pain 9/29/15 annual MDS indicative to talk on the phone in portant.				
	R16 was observed the TV. At least 6 carea, reclining in ch During the observal left the nurses static MD-D and R16 talk be overheard from throughout the day about R16's osteoal indicating that he w	ion on 2/17/16, at 9:23 a.m. sitting in the day room near other residents were in the nairs or sitting at the table. tion, medical doctor (MD)-D on and approached R16. red about R16's care and cothe nurses' station and room area. MD-D talked arthritis, pain, and head cold rould have R16's throat R16's hip pain was likely due	uld			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00586		B. WING		02/19/2016	
NAME OF I				STATE, ZIP CODE	1 02/1	<u> </u>
соок с	OMMUNITY HOSPITA	L C&NC 10 SOUTH	IEAST FIFTI N 55723	H STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21855	Continued From pa		21855			
	Assistant (NA)-A stameet with R16 and room on 2/17/16.	2/18/16, at 1:36 p.m., Nursing ated that she did hear MD-A another resident in the day JA-A also stated that MD-A sidents in the day room on ome rounds.				
	director of nursing (could develop and i resident privacy wa facility staff, includir The DON or his/her appropriate staff. T	HOD OF CORRECTION: The DON) or his/her designee implement systems to ensure sappropriately provided by all no outside providers/services. If designee could educate all the DON or his/her designee process to ensure ongoing				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

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