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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 69KJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00586

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

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

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

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/01/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **28** (L18)

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Teresa Ament, HFE NE II 06/13/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 07/28/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/31/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/09/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245392 June 13, 2017

Ms. Teresa Debevec, Administrator
Cook Community Hospital C&NC
10 Southeast Fifth Street
Cook, MN 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 April 21, 2017 the above facility is recommended for:

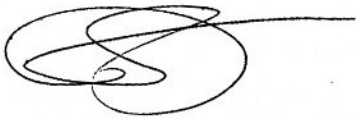
28 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,



Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 13, 2017

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

RE: Project Number S5392027

Dear Ms. Debevec:

On March 27, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 10, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 1, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 10, 2017 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 March 10, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 21, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 10, 2017, effective April 21, 2017 and therefore remedies outlined in our letter to you dated March 27, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 69KJ

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

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

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

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

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/10/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **28** (L18)

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kimberley Class, HFE NE II 04/06/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 05/09/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 27, 2017

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

RE: Project Number S5392027

Dear Ms. Debevec:

On March 10, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

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

Email: Teresa.Ament@state.mn.us
Phone: (218) 302-6151 Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 19, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 19, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 10, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of

this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 10, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING _____ B. WING _____	03/10/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a self-administration of medication assessment was completed for 1 of 1 resident (R11) observed to self administer a nebulizer treatment. Findings include: R11's quarterly Minimum Data Set (MDS) dated 12/19/16, indicated R11 had a severe cognitive deficit, had diagnoses that included dementia and chronic obstructive pulmonary disease (COPD), and had shortness of breath with exertion and when lying flat.	F 176	The Cook Community Hospital & Care Center□s Self-Administration of Medication Policy and Procedure has been reviewed and policy specific to nebulizer treatment has been added. After this policy is reviewed and approved by IDT, nebulizer administration protocols will be well defined and comply with all applicable requirements. Approval of nebulizer protocols to the Self-Administration of Medication Policy and Procedure will be complete by 4/13/17. A review was conducted of the records of	4/21/17

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

Electronically Signed | 04/05/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING _____ B. WING _____	03/10/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	Continued From page 1 R11's Care Area Assessments (CAA) dated 4/25/16, lacked assessment of R11's ability to safely self-administer medications (SAM) or nebulizers. R11's Physician Order Sheet dated 2/16/17, provided orders for nebulizer treatments (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs) including: Pulmicort 0.25 milligrams (mg)/ 2 milliliters (ml) inhaled per nebulizer twice daily and to rinse mouth with water and spit after use. R11's physician orders lacked directives for SAM of the nebulizer or any medications. R11's care plan dated 12/19/16, indicated the intervention initiated 7/29/15, directed R11 was able to self-administer the nebulizer after it had been set up by the nurse, and R11 would hold the nebulizer hand held device until the treatment was completed. R11's Care Conference Summary dated 12/15/16, indicated R11 had episodes of shortness of breath and dyspnea with ambulation and when lying flat, received nebulizer treatments, had a severely impaired cognition, and required an increase in staff assistance with activities of daily living (ADLs). The summary lacked indication of an Interdisciplinary Team (IDT) meeting assessing her ability to SAM. R11's Quarterly Assessment in the progress notes dated 12/19/16, lacked assessment or documentation regarding R11's ability to safely SAM. R11's progress notes dated 2/14/17, indicated physician orders had been received for Performist	F 176	resident R13 cited in this deficiency. A Self-Administration of Medications Assessment was found in their record that was dated 6/9/16 that stated staff to administer neb but resident was safe to leave alone during administration of nebulizer using a mask. A new assessment was completed on 3/10/17 that indicated resident can hold mask in place properly. An additional assessment will be completed once new language for nebulizer treatments has been approved to ensure compliance with policy and applicable requirements. A physician□s order was signed on 3/29/17 stating OK for resident to be left alone while Nebulizer is administered and a care plan entry was added, that will be reviewed quarterly by the interdisciplinary team. Records of all residents that have nebulizer orders have been reviewed for physician orders to ensure there are either self-administration orders or safety when left alone during nebulizer administration orders, that Self-administration assessments have been completed and care plans have been updated as needed. The self-administration status and care plans will be reviewed quarterly by the IDT. Residents who choose to self-administer their medications will be assessed and must demonstrate the ability to set up and self-administer their medications as ordered. Residents who may not be able to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING _____ B. WING _____	03/10/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	Continued From page 2 nebulizer treatment as R11 failed the trial with an inhaler medication due to inability to follow directions and cues for appropriate use. R11's progress notes dated 3/7/17, at 1:46 p.m. indicated staff had found medication on the floor next to resident, and the pharmacy had recommended crushing medications and putting them in fluids. R11's progress notes for 3/7/17, lacked documentation that R11 had not removed her nebulizer when it was finished. R11's electronic medication administration record (eMAR) dated 3/7/16, indicated R11 was administered a Pulmicort nebulizer treatment as ordered at 9:29 a.m. On 3/7/17, at 9:59 a.m. R11 was observed lying in bed with her eyes closed. R11's nebulizer mask on, and the nebulizer cup (a cup that holds the liquid medication and turns it into a mist for inhalation) contained no medication. During observations, R11 continued to lie in bed with the nebulizer running, the mask on her face and the dry nebulizer cup until licensed practical nurse (LPN)-A entered her room at 10:32 a.m. and removed the mask and turned off the nebulizer machine. On 3/7/17, at 12:16 p.m. LPN-A stated she had applied the nebulizer between 9:00 a.m. and 9:30 a.m. LPN-A stated R11 could take the nebulizer off and put it on, but would sometimes put it on when there was no medication in the cup. LPN-A stated R11 used to be independent, but had a condition change over the weekend. LPN-A verified there was no physician's order for SAM and R11 was self-administering her nebulizer.	F 176	self-administer their nebulizer treatment will be assessed to determine whether they are safe to be left alone during the nebulizer administration. Per the Nebulizer protocol in the Self-Administration of Medication policy, an assessment will be completed to determine whether they can hold the mask or hand-held device in place throughout the treatment and remove it themselves if needed. Based on the assessment, the IDT will determine if they are safe to be left alone during nebulizer administration. If so, a note must be made in the progress notes documenting that determination, a physician□s order will be obtained to allow it and the care plan will be updated with this information and reviewed quarterly by the interdisciplinary team. Nursing staff will set up and start nebulizer treatments for those residents deemed safe to be left alone during nebulizer administration. They will set a timer to alert them to return to the resident and check if treatment is complete before removing the mask/hand-held device and shutting off the machine. Several timers have been purchased to remain on the medication cart for this purpose. Nursing staff members involved in administering medications are accountable for following the facility policy regarding self-administration of medications and the nebulizer administration protocol. They will be required to attend an in-service covering	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING _____ B. WING _____	03/10/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	Continued From page 3 On 3/9/17, at 1:33 p.m. registered nurse (RN)-A stated R11 had a change in condition, and would need to be re-assessed for SAM. RN-A stated R11's nebulizer would be applied by nursing, and nursing would return to take it off when done. RN-A stated she had not looked to see if there was a physician's order for SAM. On 3/9/17, at 1:55 p.m. the director of nursing (DON) verified there should be an assessment for SAM, a physician's order for SAM, and documentation on the resident's response or ability to SAM on the medication sheet. The facility policy and procedure for Self-Administration of Medication, dated 11/28/16, directed the licensed nursing staff, interdisciplinary team (IDT) and practitioner would determine that self-administration of medications were "clinically appropriate." A specific skill assessment would be completed and would include the resident's comprehension of the purpose and proper drug dosage and administration time for the medication and ability to remove medication from the container and administer them. The policy further directed staff and practitioner to document their findings and choices of residents who were potentially capable of SAM, and the IDT and practitioner would periodically, such as during quarterly reviews and care conferences and re-evaluate a resident's ability to continue to self-administer medications utilizing the Self Administration of Medication Assessment and would be documented in the care conference nursing summary.	F 176	the following topics: 1) Review of the updated Self-Administration of Medications Policy and Procedure, and 2) Review the facility Nebulizer Administration Protocol. The in-service sessions will be held on 4/17/17 to 4/19/17 to allow nursing staff from all shifts to attend. Staff members who are unable to attend will be required to complete a make-up packet. Any new nursing staff will receive education regarding self-administration of medications and nebulizers during new employee orientation. The DON or designee will observe at least one random medication pass audit weekly, for six weeks, to ensure that the nursing staff is following the facility policy for nebulizer administration. The DON will document and review the results of each random med pass observation to guide future compliance monitoring and training needs. In addition, the results will be summarized at the quarterly Quality Assessment and Assurance Committee meeting and the need for continued compliance monitoring will be re-evaluated. The Director of Nursing is Responsible for overall compliance with this regulation.	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		4/21/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING _____ B. WING _____	03/10/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 4 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify target behaviors, to develop an individualized care plan	F 309	A review was conducted of the records of resident R1 cited in this deficiency. The care plan was found to need updates	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING _____ B. WING _____	03/10/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 5 with measurable goals, timetables and specific interventions (including non-pharmacological approaches) for the management of behavioral and psychosocial symptoms related to dementia, for 1 of 1 residents (R1) with dementia reviewed for behavioral and emotional status. Findings include: R1's admission Minimum Data Set (MDS) dated 10/31/16, indicated diagnoses of non-Alzheimer's dementia, and severely impaired cognition. The MDS further indicated behavioral symptoms (physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) occurred 1 to 3 days in the seven day assessment period; and indicated R1 did not reject evaluation or care (blood work, taking medications, activity of daily living [ADL] assistance). The MDS further indicated these behaviors did not interfere with care, had no impact on others and did not disrupt the living environment. R1's quarterly MDS dated 1/29/17, indicated an increase in behaviors from the admission MDS: physical behavioral symptoms directed towards others occurred 4-6 days in the assessment period, and R1 rejected cares 1 to 3 days in the assessment period. The MDS lacked data indicating the impact on R1 and others. R1's Care Area Assessment (CAA), dated 11/4/16, the following areas should be addressed on R1's care plan: cognitive loss and dementia, behavioral symptoms, difficulty communicating, and psychotropic drug use. R1's care plan dated 10/27/16, indicated R1	F 309	regarding behaviors and cognitive deficits. This resident had been discharged to a behavioral health unit on 2/10/17 and returned on 2/23/17. This survey occurred during the resident□s significant change assessment look back period which ended with the ARD of 3/8/17. CAAs for this assessment were completed on 3/14/17 with care plan being updated and individualized shortly thereafter. His care plan for mood and behavior was updated to include targeted behaviors and non-pharmacologic interventions to avoid behavior problems and deal with them when they occur. A cognitive deficit problem was added to address his cognitive issues related to dementia and a communication problem was added since his confusion and cognitive deficits have had severe negative effects on his communication. The care plan for this resident was updated and completed on 3/15/17. A review of resident charts found 8 other residents with documented behavior problems. Each of these resident□s care plans are being reviewed to verify that their behavior and cognition problems are individualized, with measurable goals, target behaviors, timetables and specific interventions for management of behavioral and psychological symptoms. Update of care plans for all of these affected residents will be completed by 4/21/17. All Nursing staff will attend in-services 4/17/17 to 4/19/17 on the following topics:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING _____ B. WING _____	03/10/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 6 should remain free of target behaviors regarding mood and behaviors, which were to be monitored every shift and evaluated at the quarterly care conference. Interventions included antipsychotic medications for target behaviors, however, no target behaviors were listed. The care plan lacked R1's behaviors of hitting, wandering, or threatening others. The care plan also indicated R1 should remain free of medication side effects and exhibit "appropriate" moods and behaviors. Interventions included to identify negative behavior, reinforce positive behavior and assist to identify appropriate behaviors. However, no individualized interventions were provided to manage R1's mood or behaviors. The care plan also lacked R1's cognitive loss and dementia. R1's pocket care dated 3/7/17, directed staff to use a sensor pad in bed, garter clip alert in bed and wheelchair; foot pedals on at all times; transfer belt on at all time but he does remove on his own. The pocket care plan indicated R1 had alarms. On 3/7/17, at 9:30 a.m. and again at 1:30 p.m. unsuccessful attempts were made to waken R1 for an interview. R1 was in bed asleep. On 3/8/17, at 10:37 a.m. R1 was observed in the dining room, sitting in a rock and go wheelchair, with his eyes shut. On 3/8/17, at 10:49 a.m. R1 was in the same location, with his eyes shut and his mouth open, sleeping. On 3/9/17, at 11:12 a.m. R1 was observed sleeping in bed. R1's progress notes from 12/6/16, to 3/9/17, revealed ongoing behaviors with an increase in behaviors first noted on 1/4/17. These behaviors included many attempts at self-transferring,	F 309	1. Mood and Behavior assessment 2. Behavior monitoring The MDS staff will be in-serviced on 4/19/17 on: 1. Development of individualized care plans 2. Care planning for behavior issues 3. Non-pharmacologic interventions for the management of behavioral and psychosocial symptoms The IDT will be educated on the importance of reviewing behavioral episodes, using root cause analysis to determine likely cause or trigger of negative behaviors and developing interventions (including non-pharmacologic interventions) to better manage behavior issues, avoid the identified triggers with goal of prevention. This education will occur at the IDT meeting on 4/13/17. The MDS staff will review the 24 hour reports daily to monitor for any negative behaviors. Any residents exhibiting negative behaviors that were not identified previously as having behavior issues will have a Mood and Behavior assessment completed, the behavior documented in the progress notes and the resident and their behavior brought to the IDT for analysis. The MDS staff will also audit weekly the Mood and Behavior assessments to check on the documentation of behaviors of all residents known to have behavior issues. Any targeted or negative	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING _____ B. WING _____	03/10/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 7 yelling and cursing at staff and other residents and attempting to hit staff. On 1/23/17, R1 pushed another resident in their wheelchair, and also hit a staff person in the stomach. R1's medical record also indicated documented physical and verbal behaviors toward others, rejection of care and wandering that intruded on the privacy or activities of others on 1/26/17, 1/27/17, 1/28/17, 1/30/17 and 2/3/17, through 2/8/17. Nursing assistant (NA) behavior documenting included the following categories: -moods observed on this shift -behaviors observed this shift -behavior toward others functional impairment (checklist) -behavioral symptoms not directed toward others (check list) -psychosocial symptoms -behavioral comments (text field) NA documentation revealed behaviors, moods and symptoms nearly daily since admission. R1's medical record lacked indication of interdisciplinary team review of antecedents, interventions, monitoring or assessment of R1's behaviors or moods. A physician progress note dated 1/25/17, indicated the physician was asked to observe R1 around six p.m. because this was typically when R1's behaviors increased. An increase in quetiapine (an antipsychotic medication) was ordered, and a referral was ordered to a geriatric behavioral health unit for dementia with psychosis and aggression.	F 309	behaviors that endanger the resident or others will be presented by the MDS staff to the IDT for discussion of root cause analysis and possible interventions or changes to care plans. Any audits that are brought before the IDT for analysis will be summarized at the quarterly QA meeting. Daily monitoring and weekly audits will start on 4/11/17. All processes in the plan of correction for this deficiency will be completed and on-going audits and monitoring in progress by 4/21/17. The Director of Nursing is Responsible for overall compliance with this regulation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING _____ B. WING _____	03/10/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 8	F 309		

R1's record indicated he was admitted to a behavioral health unit from 2/10/17, to 2/23/17, and he had an onset of pneumonia on 3/1/17.

A 3/3/17, a nursing rehabilitation note indicated R1 had had increased confusion since returning to the facility from the behavioral health unit, and R1's restorative ambulation and standing program was put on hold.

On 3/7/17, at approximately 11:00 a.m. registered nurse (RN)-B stated R1 had been at a behavioral health unit recently and had been "snowed" since returning.

On 3/9/17, at 7:48 a.m. the activities director (AD) stated R1 didn't respond to him the day before. The AD stated R1 used to attempt to self-transfer, and get really mad at people, but since he's come back from the behavioral health unit he's been really sleepy. The AD stated he saw R1, "Sleeping a lot." The AD stated R1 used to like to talk about his past and would do good at trivia however, now he's sleeping. The AD stated R1 used to threaten to hit other residents, but the AD stated he never saw R1 hit anyone.

On 3/9/17, at 10:11 a.m. nursing assistant (NA)-B stated R1 did a lot of self-transferring, yelling, and swinging out at staff prior to being sent to the behavioral health unit. NA-C stated R1 would "pick on whoever was in front of him" and wander into other's rooms, making some of the ladies wanting to stay in their room. NA-B stated she noticed that if she slowed down and talked to R1, or re-approached him, she could get him to respond or do what needed to be done. NA-B stated they recorded behaviors on the computer, but it was a generalized checklist, not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING _____ B. WING _____	03/10/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 9	F 309		

individualized to a resident's specific behaviors. NA-B stated there were no target behaviors listed for R1, they would communicate to the next shift regarding behaviors, and document behaviors in the computer.

On 3/9/17, at 10:16 a.m. NA-C stated she managed R1's behaviors through common sense approaches: walk away, ask another staff member to work with R1, re-approach, change your tone of voice, move away from other residents, offer something to drink, change the topic of conversation. NA-C stated the time of day affected the effectiveness of interventions. NA-C stated she was unaware of any specific, individualized behaviors to monitor for R1. NA-C stated since R1 had returned to the facility he was really drowsy, he slumped in his chair, and he had slurred speech. NA-C stated R1 also had pneumonia, but he had been able to carry on a conversation before he was sent to the behavioral health unit.

On 3/9/17, at 11:22 a.m. the director of nursing (DON) stated soon after she started employment at the facility, there were incidents regarding R1's behavior. R1 was aggressive and hit a staff member in the stomach. The DON confirmed R1's care plan lacked any target behaviors or non-pharmacological approaches or interventions either before, or after, R1's admission to the behavioral health unit. The DON could not verify if the facility interdisciplinary team had reviewed R1's behaviors on an incident by incident basis, or if they had developed individualized approaches or identified target behaviors to monitor. The DON did not reply to questions if the facility conducted root cause analysis of R1's behavioral events, nor did the DON reply to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING _____ B. WING _____	03/10/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 10 questions if any non-pharmacological approaches had been attempted or communicated to staff. The DON stated RN-B had been "working on care plans" but did not know if R1's care plan had been updated since his return from the behavioral health unit. The DON stated updating their documentation is "a work in progress." The DON stated R1 had been quiet since his return from the behavioral health unit. The DON continued that there were concerns that the effects of medications were still with R1, and they were aware R1 was not as alert as when he left, maybe not up as much as before he left, but that he also had been diagnosed with pneumonia. On 3/9/17, at 11:39 a.m. RN-B confirmed R1's care plan lacked target behaviors. A facility Resident Behavior policy dated 10/90, directed nursing and social service staff to determine and assess which behaviors require behavior tracking. Behavior tracking was to include the intensity and frequency levels, cause of the behavior and the results of the interventions. Staff were to review documentation for the effectiveness and response to interventions/approaches monthly for those resident on behavior tracking and psychoactive drugs and reassessed if needed. Staff were to be informed about interventions and remove resident from any harmful or aggressive behaviors.	F 309		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free	F 323		4/21/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING _____ B. WING _____	03/10/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11 from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a safe smoking assessment was completed to determine a resident's ability to smoke safely without supervision for 1 of 1 residents (R28) reviewed for smoking. Findings include: R28's diagnosis list indicated diagnoses that included hemiplegia (weakness on one side of the body) following a stroke, head injury, history of falls, and seizure disorder. R28's quarterly Minimum Data Set (MDS) indicated R28 had a severe cognitive deficit, and	F 323	The Cook Community Hospital & Care Center□s Smoking Policy and Procedure has been reviewed and minor changes have been made to ensure compliance with regulation. After this policy is reviewed and approved by IDT, the smoking policy will be well defined and comply with all applicable requirements. Approval of the updated Smoking Policy and Procedure will be complete by 4/13/17. A review was conducted of the records of resident R28 cited in this deficiency. No smoking assessment was found in this resident□s record. A smoking	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING _____ B. WING _____	03/10/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 12 usually understood others. R28's care plan dated 10/15/16, indicated R28 chose to smoke his pipe and was to smoke outside where staff were able to see him, R28 and staff were informed of destinations he could smoke which included on the sidewalk by the front entrance, in the grass between the building and the street, or the garden in view of the staff. R28's care plan indicated R28 had a disturbance in cognition, memory, thinking, perception, attention, decision-making, and displayed behaviors including sudden outbursts of anger and self injurious behaviors. R28's care plan further indicated R28 had self care deficits and required staff assistance with brushing teeth, hygiene, dressing, and grooming. R28's Care Area Assessments (CAA) dated 8/6/16, indicated R28's cognitive status was difficult to assess due to R28's limited communication, rejection of communication tools, refusal of adaptive equipment, and refusal to work with therapy. R28's CAAs indicated R28 became easily frustrated and angry, was impulsive, and continued to transfer self in and out of bed though had been educated he needed assistance. R28's CAAs lacked assessment of his ability to smoke independently. R28's physician notes dated 2/14/17, indicated R28 had recent self injurious behaviors. R28's progress notes dated 4/21/16, indicated R28 was smoking in the dining room, near the door. When the nurse came into the room, R28 quickly threw the pipe in his smoke bag. The nurse attempted to grab the bag as the pipe was still smoking when it was placed in the bag. R28	F 323	assessment was completed on 3/9/17. The smoking policy was discussed with the resident and he acknowledged understanding the policy. This resident has been assessed for smoking safety and it has been determined that he may be independent with smoking. However, he has in the past violated the smoking policy and been found smoking in the building. The updated smoking policy has been modified to detail how violations will be handled and these will be explained to this resident and acknowledgement of his understanding of these changes will be documented in the record. Prior to the survey resident R28 was the only resident that smoked. During the survey another resident, who is new to the facility, asked his primary physician to allow him to smoke. A smoking assessment was completed on this second resident and it was determined that he would require supervision while smoking due to physical impairments that limit movement in one of his arms. An order was signed by the physician on 3/14/17 allowing the resident to smoke three times daily. To ensure compliance with regulation and acknowledge and support a resident□s right to smoke, the smoking policy has been updated to accomplish these goals. The updated policy gives more detail regarding supervision of resident smoking, use of smoking bibs, ashtrays,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING _____ B. WING _____	03/10/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 13 refused to give the bag to the nurse, and the nurse directed R28 to go outside, where he finished smoking. The nurse explained to R28 there was no smoking in the building. The progress note further indicated R28 was again found in the dining room with the pipe in his mouth and the smell of smoke was throughout the dining room. R28 was informed he would lose smoking privileges if he were not responsible and not safe with smoking. R28's medical record lacked an assessment of R28's ability to smoke safely and independently. On 3/9/17, at 10:50 a.m. R28 was observed to be outside in the center garden/courtyard area smoking, and managing the pipe and lighter without difficulty. R28 held the lighter above his pipe and appeared to light his pipe. The flame from the lighter was visible. R28 then quickly put his pipe into the black bag on the left side of his wheelchair seat and went inside. On 3/9/17, at 10:53 a.m. R28 was sitting near the nurses station listening to music. When asked about his pipe, R28 took the pipe out of the black bag on the left side of his wheelchair seat. The tobacco had been burned down approximately to 1/2 of the inside of the pipe, but was not currently smoking or burning. When asked how he put out the pipe, R28 turned the pipe upside down and then back up, but nodded that it just goes out. On 3/9/17, at 2:05 p.m. the director of nursing (DON) stated there was a smoking assessment in the computer and believed R28 had one completed. On 3/9/17, at 2:14 p.m. registered nurse (RN)-A	F 323	fire extinguisher locations, and policy regarding violations to the smoking policy. The updated policy will be reviewed by the IDT on 4/13/17 and go into effect immediately upon their approval. The policy requires a resident who chooses to smoke to have a smoking assessment completed by the nursing staff, and documentation of the assessment stored in the resident record. The IDT will review the assessment and determine whether the resident may smoke independently or require supervision for smoking. A physicians order to allow the resident to smoke will be obtained and the resident care plan will be updated to address the resident□s smoking and safety while smoking. The Resident□s smoking status and care plan will be reviewed quarterly by the MDS coordinator and the IDT will review any changes that need to be made to status or care plan. The nursing staff will have to attend a mandatory in-service on 4/17/17 to 4/19/17 where the updated smoking policy will be reviewed and staff will indicate their understanding of the policy by signature. Staff members that are unable to attend will need to complete a smoking policy informational packet and verify their understanding by signature. Once the updated policy is in place, it will be explained to each affected resident and documentation that they indicate an understanding of the policy will be entered into their record.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING _____ B. WING _____	03/10/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 14 stated she had never seen or completed a smoking assessment, and did not know if one had been done for R28. RN-A stated R28 had smoked in the wrong place a couple of times which was a safety concern. RN-A stated R28 had been spoken to about it. The facility policy and procedure for Smoking revised 8/14, directed no smoking or use of smoking material would be allowed in the facility buildings. Staff were responsible for ensuring that smoking by residents was done in a safe manner. Residents who smoked would be evaluated for their ability to smoke safely and independently upon admission, and be re-evaluated at least quarterly to ensure they continued to be capable of smoking and safely using smoking materials. The policy further directed if a resident had an unsafe smoking incident, a new smoking evaluation would be completed.	F 323	The policy changes, verification of resident smoking assessments and physician orders, staff education, staff/resident review of updated policy, smoking bibs, ashtrays and fire extinguisher locations will all be complete by 4/21/17. All new or prospective residents of the facility will have the smoking policy reviewed with them as part of the admissions process or upon request. Random monitoring and audits will be done weekly for 6 weeks by the DON or designee. Results of the audits will be documented and place in the Survey Allegation book. Once the weekly audits for six weeks are completed, the DON or designee will complete at least one random smoking audit monthly, to ensure that the smoking policy continues to be followed. The DON will document and review the results of each random smoking audit to guide future compliance monitoring and training needs. In addition, the results will be summarized at the quarterly Quality Assessment and Assurance Committee meeting and the need for continued compliance monitoring or education will be re-evaluated. The Director of Nursing is Responsible for overall compliance with this regulation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/08/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Cook Hospital C & NC was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/05/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/08/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Cook Hospital C & NC is a 1-story building with a partial basement. The original building was constructed in 1960 with additions in 1966, 2000, and 2005 The original building buildings and additions are all Type II (111) construction, therefore, the facility was inspected as one building. The facility has a clinic, hospital and an administrative wing that are properly separated from the nursing home. The building is fully fire sprinkler protected.. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 28 beds and had a census of 25 at the time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/08/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The requirement at 42 CFR, Subpart 485.623 (d) is NOT MET.	K 000		
K 781 SS=F	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility used portable space heaters in non-resident care areas and failed to provide a policy on the use of portable space heaters in the facility that meets the requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.7.8. This deficient practice could affect 10 of 42 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:30 a.m. to 2:30 p.m. on 03/08/2017, observations and staff interview revealed that the facility has a fire place style space heater insert being used in the Fire Side Room. The heating unit was placed into a wooden fireplace assemble that does not appear to be affixed to the wall or the floor that could then be moved to different locations within the room or throughout the facility. The heating unit is not electrically hard wired, did not have any UL listings on it, and when turned on, a temp reading was taken with a heat detection gun at the vent discharge screen of 223 degrees F. The Fire	K 781	The insert was removed from the fireplace located in the Fire Side Room. A space heater use policy was written and implemented at the Cook Hospital & Care Center according to NFPA Life Safety Codes.	3/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/08/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 781	Continued From page 3 Side Room is a location that is used for activities and as a television lounge for the residents. At the time of the discovery the Maintenance Supervisor was asked if the facility had a policy for the use of space heaters and he stated, "we do not currently have a space heater use policy, but I have been working on completing one for the facility." This deficient condition was verified by a Maintenance Supervisor.	K 781		