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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 7EJR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00712

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245412**

2.STATE VENDOR OR MEDICAID NO.
(L2) **961043000**

3. NAME AND ADDRESS OF FACILITY
(L3) **COKATO MANOR**
(L4) **182 SUNSET AVENUE**
(L5) **COKATO, MN** (L6) **55321**

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 **01/26/2017** (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)
09/30

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

12.Total Facility Beds **56** (L18)

13.Total Certified Beds **56** (L17)

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(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 :
Brenda Fischer, Unit Supervisor — 01/26/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 02/17/2017 (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
01/01/1987
(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
01/03/2017
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245412
February 17, 2017

Mr. James Broich, Administrator
Cokato Manor
182 Sunset Avenue
Cokato, MN 55321

Dear Mr. Broich:

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 January 13, 2017 the above facility is certified for or recommended for:

56 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 56 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 17, 2017

Mr. James Broich, Administrator
Cokato Manor
182 Sunset Avenue
Cokato, MN 55321

RE: Project Number S7093027

Dear Mr. Broich:

On December 15, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 1, 2016. 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 January 26, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 1, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 13, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 1, 2016, effective January 13, 2017 and therefore remedies outlined in our letter to you dated December 15, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245412 Y1	A. Building B. Wing Y2	1/26/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COKATO MANOR	182 SUNSET AVENUE COKATO, MN 55321

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0164	Correction	ID Prefix F0225	Correction	ID Prefix F0226	Correction
Reg. # 483.10(h)(1)(3)(i); 483.70(i)(2)	Completed	Reg. # 483.12(a)(3)(4)(c)(1)-(4)	Completed	Reg. # 483.12(b)(1)-(3), 483.95(c)(1)-(3)	Completed
LSC	01/13/2017	LSC	01/13/2017	LSC	01/13/2017
ID Prefix F0241	Correction	ID Prefix F0323	Correction	ID Prefix F0334	Correction
Reg. # 483.10(a)(1)	Completed	Reg. # 483.25(d)(1)(2)(n)(1)-(3)	Completed	Reg. # 483.80(d)(1)(2)	Completed
LSC	01/13/2017	LSC	12/30/2016	LSC	01/13/2017
ID Prefix F0371	Correction	ID Prefix F0441	Correction	ID Prefix F0465	Correction
Reg. # 483.60(i)(1)-(3)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.90(h)(5)	Completed
LSC	01/12/2017	LSC	01/13/2017	LSC	12/30/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	BF/KJ	02/17/2017	10562	01/26/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/1/2016	☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 7EJR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00712

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(L1) **245412**

2.STATE VENDOR OR MEDICAID NO.
(L2) **961043000**

3. NAME AND ADDRESS OF FACILITY
(L3) **COKATO MANOR**
(L4) **182 SUNSET AVENUE**
(L5) **COKATO, MN** (L6) **55321**

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 **12/01/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **56** (L18)

13.Total Certified Beds **56** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(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 :
Michelle Koch, HFE NE II — 12/27/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 01/03/2017 (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
01/01/1987
(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 01/04/2017 Co.

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
December 15, 2016

Mr. James Broich, Administrator
Cokato Manor
182 Sunset Avenue
Cokato, MN 55321

RE: Project Number S5412027

Dear Mr. Broich:

On December 1, 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 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:

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

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 January 17, 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 January 17, 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 March 1, 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 June 1, 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.

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure
cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 16, 2016

Mr. James Broich, Administrator
Cokato Manor
182 Sunset Avenue
Cokato, MN 55321

RE: Project Number S5412027

Dear Mr. Broich:

On December 9, 2016, a standard survey was completed at your facility by the Minnesota Department of 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.

We are pleased to inform you that this survey resulted in no deficiencies being issued.

The Federal Form CMS-2567 is being electronically delivered.

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245412	A. BUILDING _____ B. WING _____	12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COKATO MANOR	182 SUNSET AVENUE COKATO, MN 55321

(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 On 11/28/16 to 12/1/16, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Cokato Manor was found not in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.	F 164		1/13/17

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

Electronically Signed | 12/22/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245412	A. BUILDING _____ B. WING _____	12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COKATO MANOR	182 SUNSET AVENUE COKATO, MN 55321

(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 164	Continued From page 1 §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement measures to ensure personal privacy for 1 of 1 residents (R49) reviewed for privacy. Findings include: R49's admission minimum data set (MDS) dated 7/15/16, identified R49 had severe cognitive impairment and required extensive assistance of one with all activities of daily living (ADL's).	F 164	Corrective action for those affected: Privacy was provided immediately for resident 49 after staff were notified of stated incident. Identification of others having the potential to be affected: A dignity audit was implemented throughout facility for those that require assistance with dressing to ensure	

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	245412	A. BUILDING _____ B. WING _____	12/01/2016

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F 164	Continued From page 2 During observation on 11/28/16, at 3:31 p.m. R49's bedroom door was completely open and R49 was visible from the hallway, where other residents, visitors and staff could see her. R49 was in her bed partially naked from the waist down with no blankets covering her, exposing her stomach, perineal area, and thighs. During an interview on 11/28/16, at 6:21 p.m. R49's family member (FM)-A (R49) would typically undress if she was incontinent of bowel and or urine as she did not like the "feeling" of being soiled. When interviewed on 11/28/16, at 6:55 p.m. licensed practical nurse (LPN)-A stated she was aware R49 had undressed from the waist down on several occasions in the past while lying down in bed. Further, LPN-A stated she would have shut R49's door or pulled the privacy curtain if she had known R49 was exposed to staff, visitors, and or other residents. When interviewed on 11/30/16, at 12:51 p.m. director of nursing (DON) stated she was aware R49 had undressed from the waist down in her bed on several occasions and as a result the facility had moved R49's bed against the wall for privacy. A facility policy for privacy was requested, but was not provided during the survey.	F 164	personal privacy was in place. Measures to ensure deficient practice will not recur: A facility policy for privacy was developed. Staff were re-trained on this through health care academy on 1/11/2017. Monitoring: Director of Nursing or designee will monitor weekly until compliance is achieved and report back to the Quality Assurance Committee.	
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals	F 225		1/13/17

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F 225	Continued From page 3 who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and	F 225		

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F 225	Continued From page 4 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were immediately reported to the administrator, state agency (SA) and if they were thoroughly investigated for 1 of 2 residents (R56) reviewed for allegations of abuse. Findings include: R56's 30 day Minimum Data Set (MDS) dated 7/29/16, indicated R56 had diagnoses of hypertension and depression. R56 had no verbal speech, sometimes understands, and had short and long term memory problems, cognitive skills were severely impaired, and required extensive staff assistance with activities of daily living (ADL).	F 225	Corrective action for those affected: Report made immediately after survey to OHFC. Resident (R56) was discharged 9/14/2016. Director of Nurses and Social Service Director met with staff member re-trained on the reporting policy. Potential to be affected: The Director of Nursing and Social Service Director will audit all open/closed charts (period 10/1/2016 through 12/1/2016. Measures in place/systemic changes made to ensure deficient practice will not recur:	

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F 225	Continued From page 5 R56's care plan dated 8/26/16, identified R56 as a vulnerable adult, and had an inability to summon help in an emergency due to physical or mental disability and unlikely to identify and/or escape from a potentially abusive situation. R56's progress note dated 8/17/16, indicated, "Was sitting in day room yelling loudly at TV [television]. [R43] hit him in the right arm. No injury noted, will monitor, removed from day room, did want to go into own room." Review of progress notes from 8/17/16 through 9/19/16, did not identify any investigation had been completed about the 8/17/16 incident between these two residents. Also, there was no indication the administrator was immediately notified of the incident between the residents. When interviewed on 12/1/16, at 11:03 a.m. social services director (SSD) stated R56's speech was non existent, and was only able to use gestures to communicate. SSD stated any resident to resident abuse needs to be reported, and denied any knowledge of the incident on 8/17/16. During an interview on 12/1/16, at 11:51 a.m. director of nursing (DON) stated the progress note was very vague and denied any knowledge of the incident on 8/17/16. An incident report had not been completed about the altercation between R56 and R43. She would expect staff to report this to the charge nurse, DSS, or herself to follow through. If deemed necessary, it would have been reported to the State. When interviewed on 12/1/16, at 1:17 p.m. licensed practical nurse (LPN)-A stated she was	F 225	The Social Service Director will retrain nursing staff about reporting Resident to Resident altercations and Vulnerable Adult Reporting Compliancy using Health Care Academy. Social Service Director or designee will monitor Matrix progress notes to ensure no altercation is unreported. Cokato Manor implemented New Resident to Resident identification altercation tool for nursing staff. How facility plans to monitor its performance to make sure solutions its effectiveness: The Social Service Director or designee will monitor weekly until compliance is achieved and report back to Quality Assurance Committee.	

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F 225	Continued From page 6 present and documented the incident in R56's progress notes. The residents were separated, and the incident should have been reported, but was unsure why it had not been reported. Facility policy Vulnerable Adult Abuse Prevention revision date 9/16, instructed staff to report any suspected or known abuse to the charge nurse immediately, the nurse is to report to the administrator immediately. If the determination had been made that meets the definitions in section D, identification and definitions, the incident will be reported to the state agency. The nurse is to, begin an investigation utilizing staff interview, resident interview, review of the 24 hour board and etc. The policy defined physical abuse as "includes hitting, slapping, pinching, scratching, spitting, holding roughly, etc."	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95	F 226		1/13/17

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F 226	Continued From page 7 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to operationalize their abuse prevention policy and procedure to immediately report allegations of abuse to the administrator, state agency and thoroughly investigate these allegations for 1 of 2 residents (R56) abuse allegations reviewed. Findings include: Facility policy Vulnerable Adult Abuse Prevention revision date 9/16, instructed staff to report any suspected or known abuse to the charge nurse immediately, the nurse is to report to the administrator immediately. If the determination had been made that meets the definitions in section D, identification and definitions, the incident will be reported to the state agency. The nurse is to, begin an investigation utilizing staff interview, resident interview, review of the 24 hour board and etc. The policy defined physical	F 226	How corrective action will be accomplished for residents who have been affected: It is the policy of Cokato Manor to implement written policies and procedures that prohibit the maltreatment, neglect and abuse of residents and ensure compliance with reporting in accordance with theses policies. Immediate review of incident conducted and report made to OHFC. How will facility identify other residents having potential to be affected: DON/SSD will audit open/closed charts to ensure compliance to policy of Vulnerable Adult Policy, (past 60 days - 10/1/2016 through 12/1/2016).	

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F 226	Continued From page 8 abuse as "includes hitting, slapping, pinching, scratching, spitting, holding roughly, etc." R56's 30 day Minimum Data Set (MDS) dated 7/29/16, indicated R56 had diagnoses of hypertension and depression. R56 had no verbal speech, sometimes understands, and had short and long term memory problems, cognitive skills were severely impaired, and required extensive staff assistance with activities of daily living (ADL). R56's care plan dated 8/26/16, identified R56 as a vulnerable adult, and had an inability to summon help in an emergency due to physical or mental disability and unlikely to identify and/or escape from a potentially abusive situation. R56's progress note dated 8/17/16, indicated, "Was sitting in day room yelling loudly at TV [television]. [R43] hit him in the right arm. No injury noted, will monitor, removed from day room, did want to go into own room." Review of progress notes from 8/17/16 through 9/19/16, did not identify any investigation had been completed about the 8/17/16 incident between these two residents, nor was the administrator immediately notified as identified by the facility policy. When interviewed on 12/1/16, at 11:03 a.m. social services director (SSD) stated R56's speech was non existent, and was only able to use gestures to communicate. SSD stated any resident to resident abuse needs to be reported, and denied any knowledge of the incident on 8/17/16.	F 226	Measures put into place to ensure that deficient practice will not recur: Retrain staff members using HCA as to need to immediately report all allegations of abuse/neglect/financial exploitation including Resident to Resident altercations immediately to administrator and if warranted to OHFC. Training provided 1/11/2016. Indicate plans to monitor performance: SSD or designee will audit incident reports weekly until compliance achieved and report to Quality Assurance Committee.	

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F 226	Continued From page 9 During an interview on 12/1/16, at 11:51 a.m. director of nursing (DON) stated the progress note was very vague and denied any knowledge of the incident on 8/17/16. An incident report had not been completed about the altercation between R56 and R43. She would expect staff to report this to the charge nurse, DSS, or herself to follow through. If deemed necessary, it would have been reported to the State. When interviewed on 12/1/16, at 1:17 p.m. licensed practical nurse (LPN)-A stated she was present and documented the incident in R56's progress notes. The residents were separated, and the incident should have been reported, but was unsure why it had not been reported.	F 226		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff provided a dignified experience for residents who required staff assistance for dressing, for 1 of 1 residents (R49) observed unclothed. Findings include: R49's admission Minimum Data Set (MDS) dated 7/15/16, identified R49 had severe cognitive	F 241	Corrective action for those affected: Privacy was provided immediately for resident 49 after staff were notified of stated incident. Identification of others having the potential to be affected: A dignity audit was implemented	1/13/17

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F 241	Continued From page 10 impairment and required extensive assistance of one with all activities of daily living (ADL's). During observation on 11/28/16, at 3:31 p.m. R49 was observed from the hallway, with her bedroom door open, lying in bed. R49 was undressed from the waist down exposing her abdomen, thighs, and perineal area. For approximately 20 minutes, R49 continued to be undressed exposing her perineal area as several other residents and facility staff members walked by R49's room. Facility staff made no attempts to close the door or assistance R49 in getting dressed during this time. During an interview on 11/28/16, at 6:21 p.m. with R49's family member (FM)-A stated R49 would be "very embarrassed" if facility staff and or other residents could observe R49 undressed from the hallway. Further, FM-A stated R49 would typically undress if she was incontinent of bowel and or urine as she did not like the "feeling" of being soiled. During an interview on 11/30/16, at 12:28 p.m. nursing assistant (NA)-B stated if a resident could be observed exposed from the waist down showing their perineal area it would be considered "undignified" as the resident could be placed on display where "anyone could see them." When interviewed on 11/30/16, at 12:51 p.m. director of nursing (DON) stated she was aware R49 had undressed from the waist down in her bed on several occasions. Because of this they moved R49's bed against the wall. The DON stated it would be a dignity issue if R49 could be observed undressed from the waist down laying	F 241	throughout the facility for those that require assistance with dressing to ensure personal privacy was in place. Measures to ensure deficient practice will not recur: A facility policy for privacy was developed. staff were re-trained on this through health care academy. Dignity audits will be done weekly on all shifts. Monitoring: Director of Nursing will monitor weekly until compliance is achieved and report back to the Quality Assurance Committee.	

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F 241	Continued From page 11 in her bed, visible from the hallway. A facility policy for dignity/privacy was requested but was not provided during the survey.	F 241		
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 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 comprehensively assess safety with smoking for 1 of 1 residents (R60) who smoked while residing in the facility.	F 323	How corrective action accomplished for affected resident: The resident whom was affected was	12/30/16

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F 323	Continued From page 12 Findings include: R60 was admitted to the facility on November 2, 2016. R60's undated Resident Face Sheet, identified an admission diagnosis of "Tobacco Use." During initial entrance conference on 11/28/16 at 1:36 p.m. , the director of nursing (DON) stated that the facility was a smoke free facility but went on to state they suspected one of the residents did smoke off site, but was unsure. During interview on 11/28/16 3:45 p.m., R60 stated "If you don't mind I would like to go and have a cigarette". R60 stated that he goes out the backdoor between the nursing home and the attached apartments and smokes in there area permitted for smoking of the apartment complex. R60 stated he keeps his cigarettes in his apartment and when finished smoking, the cigarettes are returned to the apartment. R60 stated the nursing home staff have not observed his smoking habits, however, stated that "They caught me before. [SSD] (social service director) said that I have been caught." During observation on 11/28/16 at 3:56 p.m., the surveyor accompanied R60 to his smoking site. R60 stated, he had not brought his cigarette back to his apartment today but had kept the cigarettes. R60 proceeded to the west side of the apartment complex to a patio area. He light the cigarette with a lighter, smoked the cigarette, and flicked the ashes to cement patio. He appropriately ashed the cigarette and extinguished the cigarette into a smoking genie when there was approximately 1 inch of cigarette	F 323	discharged 12/7/2016. How will identify others with potential to be affected: Social Service Director will audit all current residents for history of tobacco usage in medical chart. Measures put into place to ensure deficient practice will not recur: Each perspective resident (Referral Source) will be informed of Cokato Manor Smoking Policy by the Admissions Coordinator (Social Worker or Designee) - verbally prior to entrance. Admission interview; tobacco use history will be conducted and Smoking Policy review//implement Resident and Responsible Party (if designated). Monitor performance to make sure solutions effective: SSD or designee will monitor weekly until compliance achieved and report back to the Quality Assurance Committee.	

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F 323	Continued From page 13 remaining. After smoking R60 returned the cigarettes and lighter back to his apartment at 4:07 p.m.. During interview on 12/1/16 at 11:21 a.m. the social service director (SSD) stated (R60) was not smoking on the grounds or in the building. SSD stated, when (R60) signs out they are not responsible for his decisions because they are their own responsible party. SSD stated that at R60's last care conference, (R60) was aware of rules of the facility being a non-smoking facility. They had not completed any assessment for R60's smoking, because he was smoking outside the facility grounds. During interview on 12/1/16 at 1:37 p.m., the director of nursing (DON) stated she was first awareness of R60's smoking off site was on 11/29/16. The resident had not tried to smoke in the building or close to the building to her knowledge. The DON reported the facility has "Never identified any risks here, our policy is no smoking." A request was made for the facility smoking policy or policy for assessment. The facility handbook, titled "Cokato Manor Resident Handbook". undated, identified on page 56 that "Cokato Manor is a Smoke Free building. Smoking is only allowed in the designated area outside."	F 323		
F 334 SS=E	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that-	F 334		1/13/17

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F 334	Continued From page 14 (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 334		

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F 334	Continued From page 15 (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Koch, Michelle Based on interview and document review, the facility failed to implement their facility policy related to pneumococcal conjugate vaccine (PCV13) for 3 of 5 residents (R8, R30, R49) whose vaccination histories were reviewed. Findings include: Center for Disease Control and Prevention (CDC) identified, "Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 [pneumococcal polysaccharide vaccine 23] should receive a dose of PCV13. The dose of	F 334	Corrective action for those affected: R8, R30 and R49 vaccination histories were re-viewed to indicate which vaccinations were given. Identification of others having potential to be affected: A immunization audit was implemented on all current residents vaccination histories. Measures to ensure deficient practice does not recur: Cokato Manor developed a new policy	

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F 334	Continued From page 16 PCV13 should be given at least 1 year after receipt of the most recent PPSV23 dose." R8's Immunizations Record, dated 12/1/16, indicated the 98 year old had received a Pneumococcal vaccination in September of 2002, however, it did not indicate which vaccine was given. An undated listing, titled Daily Report, identified R8 had received the PPSV-23 on 9/12/02. A Physician's Order sheet, signed by medical doctor (MD)-A, dated 6/21/16, identified "Give Prevnar 13 vaccine to names highlighted on Pneumovax list." The current immunization record provided on 12/1/16 failed to indicate subsequent dosing of the Prevnar-13 immunization was provided to R8 as recommended by CDC guidelines. R30's Immunizations Record,dated 12/1/16, indicated the 81 year old had received a pneumovax on 4/21/06, however, it did not indicate which vaccine was given. An undated listing, titled Daily Report, identified R30 had received the PPSV-23 on 4/21/06. A Physician's Order sheet, signed by medical doctor (MD)-A, dated 6/21/16, identified "Give Prevnar 13 vaccine to names highlighted on Pneumovax list." The current immunization record provided on 12/1/16 failed to indicate subsequent dosing of Prevnar-13 immunization was provided to R30 as recommended by CDC guidelines. R49's Immunizations Record, undated, indicated the 73 year old had received the Pneumovax on 10/30/09, and had received the PPSV-23. The current immunization record provided on 12/1/16 failed to indicate subsequent dosing of Prevnar-13 immunization was offered as recommended by CDC guidelines.	F 334	related to pneumococcal conjugate vaccination to include the current CDC guidelines for the PCV 13 and PPSV23. Staff were re-trained on this on 12/27/2016. Monitoring: The Director of Nursing or designee will monitor weekly until compliance achieved and report back to the Quality Assurance Committee.	

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F 334	Continued From page 17 During interview on 12/1/16 at 2:40 p.m., the director of the nursing stated they currently follow the recommendations of the CDC as outlined by the Pneumococcal Vaccine Pocket Guide created by the by Immunization Action Coalition dated 1/16. DON stated they had reviewed all of the residents immunization status and followed the recommendations. A review of the facility policy, titled Cokato Manor Nursing Department Resident Immunization Policy and Procedure, dated 10/16, identified that "Pneumococcal immunizations will be offered to all new residents throughout the year, unless medically contraindicated, if no history of previous vaccinations before age 65. If medical practitioner recommends, another pneumococcal vaccination can occur after 5 years from previous vaccination." The facility policy was not following the current CDC guidelines for the PCV13 and PPSV23.	F 334		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 371		1/12/17

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F 371	Continued From page 18 (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed ensure dietary staff utilized appropriate hand hygiene during meal preparation to reduce the risk of food borne illness for 40 of 52 residents who consumed the lunch meal on 11/30/16. Findings include: During observation on 11/30/16, at 8:05 a.m. dietary aid (DA)-A donned clean gloves and started food preparation for the noon meal. With her clean gloved hands, DA-A pulled out raw hamburger meat from the walk in kitchen refrigerator, obtained a knife and began opening the raw meat packages. She used the same gloves, and placed the raw hamburger into a large mixer. DA-A opened the garbage lid with her soiled gloved hands and placed the hamburger packages into the trash. DA-A removed her soiled gloves, disposed them into the trash and donned on new pair of gloves, without first washing her hands. DA-A connected the mixing paddle to the mixer, poured the egg mixture, milk and bread crumbs into the kitchen mixer with her soiled gloves. She continued to	F 371	Corrective action for those residents found to have been affected by deficient practice: Dietary Manager (DM) reviewed resident illness with DON for 24 hours following meal. No food borne illness were noted. How facility will identify other residents potentially affected by same deficient practice: DM observed meal prep at 11/30/2016 supper meal, 12/1/2016 lunch meal, 12/1/2016 supper meal. Noted staff using gloves properly and following dietary hand washing policy. No pattern of inappropriate hand hygiene observed. Random audits are on-going and recorded. Systemic changes made to ensure deficient practice will not recur: 1. Review and update hand-washing policy as needed.	

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F 371	Continued From page 19 touch the metal storage cabinet above the garbage can, retrieved some wash cloths and wiped off the kitchen mixer and the floor where she had spilled some milk with her soiled gloves. DA-A then removed her soiled gloves and proceeded to wash her hands. During an interview on 11/30/16 at 3:02 p.m., DA-A stated any time she touched a dirty surface such as a garbage can, she should wash her hands because of risk of contamination to the food which she was preparing. When interviewed on 11/30/16 at 11:49 p.m. dietary manager (DM) stated the dietary aids are expected to wash their hands any time they come into contact with dirty surfaces such as garbage cans. The facility policy titled, "Dietary Personnel" dated 04/2010, identifies employees were expected to wash hands if hands were visibly soiled, anytime after removing gloves and before handling any clean dishes or food.	F 371	2. Self audit and supervisor glove competency checklist will be completed on all dietary staff to ensure they are following facility policies on safe hand washing-practices. DM and/or designee will complete supervisor glove competency checklist following a staff interview and 15-20 minute observation of staff performing regular dietary routine. Staff to be re-trained on safe practices and retry validation if not following proper technique. 3. Health Care Academy will be assigned to all dietary staff. This will include "Hand Hygiene" and "Safe Food Handling" to review appropriate hand-washing technique and how hand-washing will prevent cross contamination. 4. DM and Consulting Dietician to conduct staff in-service on hand-washing and preventing cross contamination. This will include correct hand-washing technique, review health care academy, review of hand-washing audits. 5. Updated hand-washing policy, health care academy lessons and hand-washing audit will remain part of new staff orientation and annual training. Facility plan to monitor performance: DM and/or designee will audit weekly on both shifts of dietary staff to ensure that they are practicing proper hand-washing and safe food handling techniques. This deficiency and audits will be reviewed at the next regular Quality Assurance meeting.	

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F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 441		1/13/17

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F 441	Continued From page 21 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to develop an infection control program which included trending and analysis of resident infection data to reduce the risk of spread of infections to other residents in the facility. This had the potential to affect all 54 residents who resided in the facility. Findings include: The facility's infection control logs were reviewed from May, 2016, through November, 2016. The	F 441	Corrective action for those affected and those who have potential to be affected: Cokato Manor's infection logs were audited from May 2016 to current to identify resolution of symptoms, on-going surveillance, tracking and summarizing of infections and micro organisms to identify if there was a pattern. New graphs were created to illustrate specific areas of infection.	

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F 441	Continued From page 22 facility provided two logs for each month. One of the logs titled "Resident Infection" contained information including; resident name, room number, date of onset, microorganism, type of infection (urinary tract infection as "UTI", respiratory infection as "Resp", skin, eye, and other), and antibiotic rx (prescription) and duration. The infections were tallied according to category. A second log, untitled, contained information including; date/time, resident name, signs and symptoms, with an additional column for "comments required". Information recorded on the second log included resident symptoms of weakness, cough, elevated temp, vomiting, cold symptoms, runny nose, etc. Review of these logs identified the following: The Resident Infection form for September 2016, indicated three residents had been treated with antibiotics for infections; 1 incident of UTI's was identified (with microorganisms identified as "None in chart"), one resident was identified as respiratory infection, and one were identified as "skin" infections., The Resident Infection log identified antibiotic therapy used to treat the infection, however, no symptoms were noted, and no resolution date was indicated to determine if the antibiotic was effective and if the infection resolved. The Resident Infection log did not indicate if the infection was hospital or facility acquired infections. There was a list of antibiotic used to treat the infection, however, there was no evidence of ongoing surveillance, tracking, or summarizing of infections or organisms to identify if there was a pattern. The untitled September 2016 log had multiple entries for individual	F 441	Measures to ensure deficient practice does not recur: Cokato Manor has scheduled a on-site visit with ICAR on January 5, 2017. Staff were re-trained on Cokato Manor infection control policy on 12/27/2016 which includes corrective actions related to infections. A Infection Preventionist will be designated who will be responsible for the facility's infection prevention and control program. Monitoring: The infection preventionist or designee will monitor weekly until compliance is achieved and report back to the Quality Assurance Committee.	

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F 441	Continued From page 23	F 441		

residents, providing chronological information regarding symptoms exhibited throughout the course of illness. The facility lacked an analysis and/or investigation to identify if there were patterns of infections identified.

The Resident Infection form for October 2016, indicated five residents had symptoms of infection. One resident was identified as having respiratory symptoms, with no microorganisms identified and course of antibiotic treatment outlined. Two residents were identified as having a skin infections (no microorganisms identified) and antibiotic therapy identified. The log identified that two residents were identified as having "other" infections with no microorganisms identified, and course of antibiotic therapy outline. The specifics for these "other" infections was not identified in the the log. A review of the second untitled log October 2016 identified several progressive notes including signs and symptoms of the illness and infections experienced by residents. The logs did not reflect whether the infection was facility or or hospital acquired and no resolution date was indicated for the infections. There was no evidence of ongoing surveillance, tracking, or summarizing of infections or microorganisms to identify if there was a pattern.

The Resident Infection form for November 2016 indicated one resident had been treated for a UTI, with no microorganisms identified and the course of antibiotics outlined. A review of the untitled log identified the microorganism growth. The Resident Infection log identified four residents had experienced respiratory infections, with the antibiotic therapy outlined. One resident was identified as having two skin infections, no

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F 441	Continued From page 24 microorganisms identified, and outlined the course of consecutive antibiotic therapies. The Resident Infection log identified four other residents were treated for "Other" infections with antibiotics prescribed. These infections were not specifically identified on the the log, however, a review of the second log, noted symptoms identified for three of four of the "other" infections. The untitled November 2016 log contained progressive entries for residents and their presentation of symptoms, including vital signs (VS), oxygen saturation levels, and antibiotic therapy provided. The logs did not consistently identify resolution of symptoms. There was no evidence of ongoing surveillance, tracking, or summarizing of infections or microorganisms to identify if there was a pattern. During interview on 12/1/16, at 9:15 a.m., director of nursing (DON) stated she and licensed practical nurse (LPN)-B compiled information on residents and staff who have had infections, they look for trends and work to reduce the infection rate. DON stated she has tracked prevalence of infections with the use of graphs, but this information was not broken down into specific areas of infection, merely the presence of infections. She has worked closely with LPN-B and medical doctor (MD)-A on improving antibiotic stewardship. DON stated she did not document or have any evidence of ongoing surveillance, tracking, or summarizing of infections or microorganisms to identify if there was a pattern. DON stated, she just knows the information so they had not documented the specific plans and interventions for these infections.	F 441		

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F 441	Continued From page 25 A facility policy titled Infection Surveillance, copyright 2013, identified under Infection Surveillance-Overview, Purpose: "Infection prevention begins with ongoing surveillance to identify infections, that are causing, or have to the potential to cause an outbreak." It goes on to stated "This facility closely monitors all residents who exhibit signs/symptoms of infection through ongoing surveillance and has a systemic method of collecting, consolidating and analyzing data concerning the frequency and cause of a given disease or event. "	F 441		
F 465 SS=E	483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (h) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (h)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide maintenance services necessary to maintain sanitary conditions for 5 resident rooms (191-B, 120-B, 202-A, 203-A, and 127-A), which affected 6 of the 10 resident that lived in these rooms. Findings include:	F 465	Corrective action for those residents to have been affected by deficient practices: The ceiling tile that had discoloration spots in room 191B have been replaces and the roof has been repaired (documentation attached). The rooms that were reported to have wall damage have been repaired and repainted, 120B,	12/30/16

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F 465	Continued From page 26 On 11/30/16, at 8:52 a.m. an environmental tour of the facility was conducted with maintenance supervisor (MS) that identified the following: Room 191-B, had a large brown colored stain on ceiling tiles. There was a wet area on ceiling tile at the edge of the wall with clear liquid flowing down the wall. MS looked at the area and stated he was aware that repairs were needed. The facility had been scheduled to replace the roof this past summer, but they had not completed this. They had received an estimate, but decided to repair windows of the dining room and not fix the roof. MS identified the ceiling tiles and roof needed to be replaced and they did not have a contract to fix the roof nor any dates of when this would be completed. Room 120-B, had two large scrapes approximately 6 inches long and 1/4 inch wide exposing the sheetrock located on the wall behind the residents headboard. There were two scraped areas of exposed sheet rock on wall above residents bedside table. Room 202-A, had 3 area that were approximately 24 inch by 3 inch scraps on the wall exposing the sheetrock, that was behind the residents headboard. There were two areas of exposed sheet rock approximately 9 inches by 5 inches on the wall behind the residents bed. Room 203-A, had a several large areas of sheetrock that was scraped behind the residents bed, and recliner. Room 127-A, had a large chipped area on inside of wooden bathroom door.	F 465	202A, 203A. The bathroom door has been repaired, sanded and stained, 127A. Identify other residents having potential to be affected by same deficient practice: All resident rooms have been inspected for damage to the walls, ceilings and doors. Measure put into place to ensure deficient practice will not recur: Maintenance supervisor or assigned individual will do quarterly inspection of rooms and common areas to check for discoloration of ceiling tile, wall, floor and door damage. Any damage will be repaired within 2 working days of being found, unless requiring outside contractors to be involved in the repair. Monitor performance: We have implemented a new maintenance policy for Inspections and Repairs for Cokato Manor. After quarterly inspections have been repaired, and individual from the Quality Assurance Team or Administrator will do a walk through inspection and sign that repairs have been completed. Initial inspection and repairs will be completed by 12/20/2016. Quarterly inspections will begin in January. This deficiency will be reviewed at the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245412	A. BUILDING _____ B. WING _____	12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COKATO MANOR	182 SUNSET AVENUE COKATO, MN 55321

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F 465	Continued From page 27 The MS stated residents room were periodically repaired when the walls got scraped. If the area needed to be repaired the nursing staff filled out a form at the desk and placed it on their bulletin board. They also do checks of the entire building every two months and prioritize what needs to be repaired. The MS was unaware rooms 120-B, 127-A, 191-B, 202-A, and 203-A needed repair work completed. A facility maintenance policy was requested but was not provided during the survey.	F 465	next quarterly Quality Assurance Meeting. Quarterly Inspections will become part of the regular QA meetings in the future.	

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	245412	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COKATO MANOR	**182 SUNSET AVENUE** **COKATO, MN 55321**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State fire Marshal Division. At the time of this survey, Cokato Manor was found in substantial 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. Cokato Manor is a one story building with a partial basement. The building is of Type II (000) construction and was built at five different times. The original building was constructed in 1964. Additions were constructed in 1984, 1994, 1999 and 2006. The 1999 addition includes a physical therapy area and a two story assisted living facility of Type V (111) construction. The two stories assisted living building is separated from the physical therapy portion of the addition by a two hour fire rated building separation wall. The building is fully sprinklered and there is supervised smoke detection located in the corridors and spaces open to the corridors. Smoke detectors located in the resident room report to the nurse ' s station only. The facility has 56 certified beds. All 56 beds are dually certified for Medicare and Medicaid. At the time of the survey the census was 50. The requirement at 42 CFR, Subpart 483.70(a) is MET as evidenced by:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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.

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
December 15, 2016

Mr. James Broich, Administrator
Cokato Manor
182 Sunset Avenue
Cokato, MN 55321

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5412027

Dear Mr. Broich:

The above facility was surveyed on November 28, 2016 through December 1, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

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(s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00712	A. BUILDING: _____ B. WING _____	12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COKATO MANOR	182 SUNSET AVENUE COKATO, MN 55321

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On November 28-December 1, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess safety with smoking for 1 of 1 residents (R60) who smoked while residing in the facility. Findings include: R60 was admitted to the facility on November 2, 2016. R60's undated Resident Face Sheet, identified an admission diagnosis of "Tobacco Use." During initial entrance conference on 11/28/16 at 1:36 p.m. , the director of nursing (DON) stated	2 830	Corrected	12/30/16

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2 830	Continued From page 3	2 830		

that the facility was a smoke free facility but went on to state they suspected one of the residents did smoke off site, but was unsure.

During interview on 11/28/16 3:45 p.m., R60 stated "If you don't mind I would like to go and have a cigarette". R60 stated that he goes out the backdoor between the nursing home and the attached apartments and smokes in there area permitted for smoking of the apartment complex. R60 stated he keeps his cigarettes in his apartment and when finished smoking, the cigarettes are returned to the apartment. R60 stated the nursing home staff have not observed his smoking habits, however, stated that "They caught me before. [SSD] (social service director) said that I have been caught."

During observation on 11/28/16 at 3:56 p.m., the surveyor accompanied R60 to his smoking site. R60 stated, he had not brought his cigarette back to his apartment today but had kept the cigarettes. R60 proceeded to the west side of the apartment complex to a patio area. He light the cigarette with a lighter, smoked the cigarette, and flicked the ashes to cement patio. He appropriately ashed the cigarette and extinguished the cigarette into a smoking genie when there was approximately 1 inch of cigarette remaining. After smoking R60 returned the cigarettes and lighter back to his apartment at 4:07 p.m..

During interview on 12/1/16 at 11:21 a.m. the social service director (SSD) stated (R60) was not smoking on the grounds or in the building. SSD stated, when (R60) signs out they are not responsible for his decisions because they are their own responsible party. SSD stated that at R60's last care conference, (R60) was aware of

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2 830	Continued From page 4 rules of the facility being a non-smoking facility. They had not completed any assessment for R60's smoking, because he was smoking outside the facility grounds. During interview on 12/1/16 at 1:37 p.m., the director of nursing (DON) stated she was first awareness of R60's smoking off site was on 11/29/16. The resident had not tried to smoke in the building or close to the building to her knowledge. The DON reported the facility has "Never identified any risks here, our policy is no smoking." A request was made for the facility smoking policy or policy for assessment. The facility handbook, titled "Cokato Manor Resident Handbook". undated, identified on page 56 that "Cokato Manor is a Smoke Free building. Smoking is only allowed in the designated area outside." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review the facility policy for assessment of resident smoking, and make any needed changes to reflect current regulations for safety. The DON could then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21000	MN Rule 4658.0610 Subp. 4 Dietary Staff Requirements-Hygiene. Subp. 4. Hygiene. Dietary staff must thoroughly wash their hands and the exposed portions of their arms with soap and warm water in a hand washing facility before starting work, during work	21000		1/12/17

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21000	Continued From page 5 as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed ensure dietary staff utilized appropriate hand hygiene during meal preparation to reduce the risk of food borne illness for 40 of 52 residents who consumed the lunch meal on 11/30/16. Findings include: During observation on 11/30/16, at 8:05 a.m. dietary aid (DA)-A donned clean gloves and started food preparation for the noon meal. With her clean gloved hands, DA-A pulled out raw hamburger meat from the walk in kitchen refrigerator, obtained a knife and began opening the raw meat packages. She used the same gloves, and placed the raw hamburger into a large mixer. DA-A opened the garbage lid with her soiled gloved hands and placed the hamburger packages into the trash. DA-A removed her soiled gloves, disposed them into the trash and donned on new pair of gloves, without first washing her hands. DA-A connected the mixing paddle to the mixer, poured the egg mixture, milk and bread crumbs into the kitchen mixer with her soiled gloves. She continued to touch the metal storage cabinet above the garbage can, retrieved some wash cloths and wiped off the kitchen mixer and the floor where she had spilled some milk with her soiled gloves. DA-A then removed her soiled gloves and	21000	Corrected.	

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21000	Continued From page 6 proceeded to wash her hands. During an interview on 11/30/16 at 3:02 p.m., DA-A stated any time she touched a dirty surface such as a garbage can, she should wash her hands because of risk of contamination to the food which she was preparing. When interviewed on 11/30/16 at 11:49 p.m. dietary manager (DM) stated the dietary aids are expected to wash their hands any time they come into contact with dirty surfaces such as garbage cans. The facility policy titled, "Dietary Personnel" dated 04/2010, identifies employees were expected to wash hands if hands were visibly soiled, anytime after removing gloves and before handling any clean dishes or food. SUGGESTED METHOD OF CORRECTION: The director of dietary or designee could review policy's about hand washing in the dietary department. The director of dietary or designee could conduct random audits to ensure appropriate hand hygiene is being implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.	21375		1/13/17

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21375	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to develop an infection control program which included trending and analysis of resident infection data to reduce the risk of spread of infections to other residents in the facility. This had the potential to affect all 54 residents who resided in the facility. Findings include: The facility's infection control logs were reviewed from May, 2016, through November, 2016. The facility provided two logs for each month. One of the logs titled "Resident Infection" contained information including; resident name, room number, date of onset, microorganism, type of infection (urinary tract infection as "UTI", respiratory infection as "Resp", skin, eye, and other), and antibiotic rx (prescription) and duration. The infections were tallied according to category. A second log, untitled, contained information including; date/time, resident name, signs and symptoms, with an additional column for "comments required". Information recorded on the second log included resident symptoms of weakness, cough, elevated temp, vomiting, cold symptoms, runny nose, etc. Review of these logs identified the following: The Resident Infection form for September 2016, indicated three residents had been treated with antibiotics for infections; 1 incident of UTI's was identified (with microorganisms identified as "None in chart"), one resident was identified as	21375	Corrected.	

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21375	Continued From page 8	21375		

respiratory infection, and one were identified as "skin" infections., The Resident Infection log identified antibiotic therapy used to treat the infection, however, no symptoms were noted, and no resolution date was indicated to determine if the antibiotic was effective and if the infection resolved. The Resident Infection log did not indicate if the infection was hospital or facility acquired infections. There was a list of antibiotic used to treat the infection, however, there was no evidence of ongoing surveillance, tracking, or summarizing of infections or organisms to identify if there was a pattern. The untitled September 2016 log had multiple entries for individual residents, providing chronological information regarding symptoms exhibited throughout the course of illness. The facility lacked an analysis and/or investigation to identify if there were patterns of infections identified.

The Resident Infection form for October 2016, indicated five residents had symptoms of infection. One resident was identified as having respiratory symptoms, with no microorganisms identified and course of antibiotic treatment outlined. Two residents were identified as having a skin infections (no microorganisms identified) and antibiotic therapy identified. The log identified that two residents were identified as having "other" infections with no microorganisms identified, and course of antibiotic therapy outline. The specifics for these "other" infections was not identified in the the log. A review of the second untitled log October 2016 identified several progressive notes including signs and symptoms of the illness and infections experienced by residents. The logs did not reflect whether the infection was facility or or hospital acquired and no resolution date was indicated for the infections. There was no evidence of ongoing

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21375	Continued From page 9	21375		

surveillance, tracking, or summarizing of infections or microorganisms to identify if there was a pattern.

The Resident Infection form for November 2016 indicated one resident had been treated for a UTI, with no microorganisms identified and the course of antibiotics outlined. A review of the untitled log identified the microorganism growth. The Resident Infection log identified four residents had experienced respiratory infections, with the antibiotic therapy outlined. One resident was identified as having two skin infections, no microorganisms identified, and outlined the course of consecutive antibiotic therapies. The Resident Infection log identified four other residents were treated for "Other" infections with antibiotics prescribed. These infections were not specifically identified on the the log, however, a review of the second log, noted symptoms identified for three of four of the "other" infections. The untitled November 2016 log contained progressive entries for residents and their presentation of symptoms, including vital signs (VS), oxygen saturation levels, and antibiotic therapy provided. The logs did not consistently identify resolution of symptoms. There was no evidence of ongoing surveillance, tracking, or summarizing of infections or microorganisms to identify if there was a pattern.

During interview on 12/1/16, at 9:15 a.m., director of nursing (DON) stated she and licensed practical nurse (LPN)-B compiled information on residents and staff who have had infections, they look for trends and work to reduce the infection rate. DON stated she has tracked prevalence of infections with the use of graphs, but this information was not broken down into specific areas of infection, merely the presence of

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21375	Continued From page 10 infections. She has worked closely with LPN-B and medical doctor (MD)-A on improving antibiotic stewardship. DON stated she did not document or have any evidence of ongoing surveillance, tracking, or summarizing of infections or microorganisms to identify if there was a pattern. DON stated, she just knows the information so they had not documented the specific plans and interventions for these infections. A facility policy titled Infection Surveillance, copyright 2013, identified under Infection Surveillance-Overview, Purpose: "Infection prevention begins with ongoing surveillance to identify infections, that are causing, or have to the potential to cause an outbreak." It goes on to stated "This facility closely monitors all residents who exhibit signs/symptoms of infection through ongoing surveillance and has a systemic method of collecting, consolidating and analyzing data concerning the frequency and cause of a given disease or event. " SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and/or revise policies and procedures for infection control monitoring. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	21375		

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21426	Continued From page 11	21426		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement interventions to ensure appropriate screening for tuberculosis (TB) was conducted for 3 of 5 employees (nursing assistants (NAs)-A, B and C) reviewed for TB. Findings include: NA-A's start of employment date was 7/6/16. Review of NA-As personnel record indicated NA-A received a tuberculin skin test (TST) on 6/29/16 which was negative with 0 mm	21426	Corrected.	1/13/17

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21426	Continued From page 12 (millimeters) of induration on 7/1/16. A second step TST had been administered on 7/23/16, with results read at 0 mm on 7/25/16. NA-A's Baseline TB Screening Tool for Health Care Workers (HCWs) was completed on 7/29/16. The symptom screening tool was not completed until after the TST was conducted. NA-B's start of employment was 6/23/16. Review of NA-B's personnel record identified NA-B received a TST on 6/21/16, which was read at 0 mm induration on 6/23/16. A second step TST had been administered on 7/2/16 and was read on 7/4/16 at 0 mm induration. The symptom screening tool was not completed until 7/13/16, after the TST were completed. NA-C's start of employment was 11/30/15. Review of NA-C's personnel record identified NA-C received a TST on 10/19/15, which was read at 0 mm induration on 10/21/15. A second step TST had been administered on 12/16/16 and was read on 12/18/16 at 0 mm induration. The symptom screening tool was completed on 12/08/15, after the TST's were completed. The facility's policy and procedure, titled Cokato Manor Employee Tuberculosis Program, dated 8/16, identified that "A. Employees must have a baseline Mantoux test within three months prior to employment or at the time of employment. B. Complete TB screening tool for Health Care Workers (HCW)." The screening tool identified "If TB symptoms are present, promptly refer HCW for a chest X-ray and medical evaluation before starting work. Do not wait for the TST or TB blood test result."	21426		

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21426	Continued From page 13 SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the assessment process for employees to be sure the documentation of the tuberculin screens and tests are completed, the administrator or designee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review the TB policy and procedure to ensure symptom screenings are completed, then inservice staff and audit for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide maintenance services necessary to maintain sanitary conditions for 5 resident rooms (191-B, 120-B, 202-A, 203-A, and 127-A), which affected 6 of the 10 resident that lived in these rooms. Findings include:	21665	Corrected.	12/30/16

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21665	Continued From page 14 On 11/30/16, at 8:52 a.m. an environmental tour of the facility was conducted with maintenance supervisor (MS) that identified the following: Room 191-B, had a large brown colored stain on ceiling tiles. There was a wet area on ceiling tile at the edge of the wall with clear liquid flowing down the wall. MS looked at the area and stated he was aware that repairs were needed. The facility had been scheduled to replace the roof this past summer, but they had not completed this. They had received an estimate, but decided to repair windows of the dining room and not fix the roof. MS identified the ceiling tiles and roof needed to be replaced and they did not have a contract to fix the roof nor any dates of when this would be completed. Room 120-B, had two large scrapes approximately 6 inches long and 1/4 inch wide exposing the sheetrock located on the wall behind the residents headboard. There were two scraped areas of exposed sheet rock on wall above residents bedside table. Room 202-A, had 3 area that were approximately 24 inch by 3 inch scraps on the wall exposing the sheetrock, that was behind the residents headboard. There were two areas of exposed sheet rock approximately 9 inches by 5 inches on the wall behind the residents bed. Room 203-A, had a several large areas of sheetrock that was scraped behind the residents bed, and recliner. Room 127-A, had a large chipped area on inside of wooden bathroom door. The MS stated residents room were periodically	21665		

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21665	Continued From page 15 repaired when the walls got scraped. If the area needed to be repaired the nursing staff filled out a form at the desk and placed it on their bulletin board. They also do checks of the entire building every two months and prioritize what needs to be repaired. The MS was unaware rooms 120-B, 127-A, 191-B, 202-A, and 203-A needed repair work completed. A facility maintenance policy was requested but was not provided during the survey. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review policies and procedures for ensuring timely repairs of the physical plant, then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff provided a dignified experience for residents who required staff assistance for dressing, for 1 of 1 residents (R49) observed unclothed. Findings include:	21805	Corrected.	1/13/17

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21805	Continued From page 16 R49's admission Minimum Data Set (MDS) dated 7/15/16, identified R49 had severe cognitive impairment and required extensive assistance of one with all activities of daily living (ADL's). During observation on 11/28/16, at 3:31 p.m. R49 was observed from the hallway, with her bedroom door open, lying in bed. R49 was undressed from the waist down exposing her abdomen, thighs, and perineal area. For approximately 20 minutes, R49 continued to be undressed exposing her perineal area as several other residents and facility staff members walked by R49's room. Facility staff made no attempts to close the door or assistance R49 in getting dressed during this time. During an interview on 11/28/16, at 6:21 p.m. with R49's family member (FM)-A stated R49 would be "very embarrassed" if facility staff and or other residents could observe R49 undressed from the hallway. Further, FM-A stated R49 would typically undress if she was incontinent of bowel and or urine as she did not like the "feeling" of being soiled. During an interview on 11/30/16, at 12:28 p.m. nursing assistant (NA)-B stated if a resident could be observed exposed from the waist down showing their perineal area it would be considered "undignified" as the resident could be placed on display where "anyone could see them." When interviewed on 11/30/16, at 12:51 p.m. director of nursing (DON) stated she was aware R49 had undressed from the waist down in her bed on several occasions. Because of this they moved R49's bed against the wall. The DON	21805		

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21805	Continued From page 17 stated it would be a dignity issue if R49 could be observed undressed from the waist down laying in her bed, visible from the hallway. A facility policy for dignity/privacy was requested but was not provided during the survey. SUGGESTED METHOD OF CORRECTION: The Director of Nursing Services or designee could develop, review, and/or revise policies and procedures to ensure all residents' dignity is maintained. They could educate their staff on their policies, and develop a monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21805		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to	21990		1/13/17

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21990	Continued From page 18 comply with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were immediately reported to the administrator, state agency (SA) and if they were thoroughly investigated for 1 of 2 residents (R56) reviewed for allegations of abuse. Findings include: R56's 30 day Minimum Data Set (MDS) dated 7/29/16, indicated R56 had diagnoses of hypertension and depression. R56 had no verbal speech, sometimes understands, and had short and long term memory problems, cognitive skills were severely impaired, and required extensive staff assistance with activities of daily living (ADL). R56's care plan dated 8/26/16, identified R56 as a vulnerable adult, and had an inability to summon help in an emergency due to physical or mental disability and unlikely to identify and/or escape from a potentially abusive situation. R56's progress note dated 8/17/16, indicated, "Was sitting in day room yelling loudly at TV [television]. [R43] hit him in the right arm. No injury noted, will monitor, removed from day room, did want to go into own room." Review of progress notes from 8/17/16 through 9/19/16, did not identify any investigation had been completed about the 8/17/16 incident between these two residents. Also, there was no indication the administrator was immediately notified of the incident between the residents.	21990	Corrected.	

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21990	Continued From page 19 When interviewed on 12/1/16, at 11:03 a.m. social services director (SSD) stated R56's speech was non existent, and was only able to use gestures to communicate. SSD stated any resident to resident abuse needs to be reported, and denied any knowledge of the incident on 8/17/16. During an interview on 12/1/16, at 11:51 a.m. director of nursing (DON) stated the progress note was very vague and denied any knowledge of the incident on 8/17/16. An incident report had not been completed about the altercation between R56 and R43. She would expect staff to report this to the charge nurse, DSS, or herself to follow through. If deemed necessary, it would have been reported to the State. When interviewed on 12/1/16, at 1:17 p.m. licensed practical nurse (LPN)-A stated she was present and documented the incident in R56's progress notes. The residents were separated, and the incident should have been reported, but was unsure why it had not been reported. Facility policy Vulnerable Adult Abuse Prevention revision date 9/16, instructed staff to report any suspected or known abuse to the charge nurse immediately, the nurse is to report to the administrator immediately. If the determination had been made that meets the definitions in section D, identification and definitions, the incident will be reported to the state agency. The nurse is to, begin an investigation utilizing staff interview, resident interview, review of the 24 hour board and etc. The policy defined physical abuse as "includes hitting, slapping, pinching, scratching, spitting, holding roughly, etc."	21990		

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21990	Continued From page 20 SUGGESTED METHOD OF CORRECTION: The Administrator and/or designee could review and inservice facility staff to their policy in regard to abuse and neglect, and what to report. They could develop a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21990		