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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: E5HM

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 182**
(L4) **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 **04/09/2014** (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):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor — 4/09/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 05/14/2014 (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
04/08/2014
(L33)

DETERMINATION APPROVAL

Provider Number: 24-5412
Item 16 Continuation for CMS-1539

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective 3/24/2014, the facility is certified for 56 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 15, 2014

Mr. Tom Opatz, Interim Administrator
Cokato Manor
182 Sunset Avenue
Cokato, Minnesota 55321

RE: Project Number S5412024

Dear Mr. Opatz:

On March 3, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 13, 2014 that included an investigation of complaint number H5412010. 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 April 9, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 28, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 13, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 24, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 13, 2014, effective March 24, 2014 and therefore remedies outlined in our letter to you dated March 3, 2014, 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
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245412	A. Building B. Wing	4/9/2014

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **03/24/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **03/24/2014**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **03/24/2014**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/24/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **03/24/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/24/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	05/08/2014	10562	4/9/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/13/2014			

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245412	A. Building B. Wing 01 - MAIN BUILDING 01	3/28/2014

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 02/18/2014	ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 02/20/2014	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By BF/KJ	Date: 5/13/2014	Signature of Surveyor: 27200	Date: 3/28/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/13/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: E5HM

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 182**
(L4) **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 **02/13/2014** (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:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * 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):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Bruce Melchert, HFE NE II 03/24/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 04/07/2014 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

Provider Number: 24-5412
Item 16 Continuation for CMS-1539

At the time of the standard survey completed 2/13/2014, the facility was not in substantial compliance and the most serious deficiencies were found 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 as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7002 0860 0006 5192 3995

March 3, 2014

Mr. Tom Opatz, Administrator
Cokato Manor
182 Sunset Avenue
Cokato, Minnesota 55321

RE: Project Number S5412024, H5412010

Dear Mr. Opatz:

On February 13, 2014, 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. In addition, at the time of the February 13, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5412010.

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. In addition, at the time of the February 13, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5412010 that was found to be unsubstantiated.

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

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

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

<u>Plan of Correction</u> - 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
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557

Phone: (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 March 25, 2014, 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 March 25, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 13, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the

identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 13, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Enclosure

cc: Licensing and Certification File 5412s14.rtf

Received via e-mail 3/24/14

Cokato Manor

Provider number: 245412

PLAN OF CORRECTION

F157 Notify of changes

Corrective action for those affected: R 55's doctor was updated during the survey about current blood sugar readings and gave clear parameters for notifying the physician if the readings are abnormal.

Identification of others having the potential to be affected: Nursing department audited all diabetic residents for clear parameters on blood sugar readings and when to notify the physician.

Measures to ensure practice will not recur: Education provided on March 17, 2014 to nurses regarding the importance of updating doctor when abnormal blood sugar reading. Policy implemented regarding when to update the doctor if abnormal blood sugar reading.

Monitoring: This Director of Nursing or designee will monitor blood sugar readings and notification of doctor if needed weekly until compliance is obtained and report back to the Quality Assurance Committee.

Date of completion: March 24, 2014.

F309 Provide care/services for highest well being

Corrective action for those affected: R 55's doctor was updated on the abnormal blood sugar and late administration of her insulin during the survey. Education was provided to the nurse involved on the late administration of the insulin on the importance of updating doctor on abnormal blood sugar readings.

Identification of others having the potential to be affected: Nursing department audited all diabetic resident administration history to identify abnormal blood sugar readings and any late administration of insulin dose.

Monitoring: The DON or designee will review the blood sugar readings and the insulin administration history weekly along with any needed notification of physician weekly until compliance is met and report back to the Quality Assurance Committee.

Date of completion: March 24, 2014.

F325 Maintain nutrition status unless unavoidable

Corrective action for those affected: R 17 received his nutritional supplement immediately after this discrepancy was noted. R 17 was placed on a weekly weight to monitor nutritional status.

3/24/14
KA accepted

Identification of others having the potential to be affected: The CDM and RN coordinator audited doctor's orders with the information the kitchen used to provide the supplements. The CDM and dietician audited resident record to identify any others nutritionally at risk based on weight loss.

Measures to ensure the practice will not recur: CDM implemented a new tracking form to coordinate communication between the nursing department and dietary. Initiated a facility policy regarding nutritional support for residents, including parameters of weight loss, abnormal blood sugar readings or abnormal lab values.

Monitoring: The CDM or designee will monitor weight loss weekly, complete quarterly assessments on all residents within the appropriate time frame as designated by the RAI process and ensure an appropriate goal is in place. MDS nurse or designee will review medication administration history which reflects the amount consumed of supplements. CDM or designee will review nutritional intake flowsheet which reflects the amount consumed of supplements. This monitoring will be done weekly until compliance is reached and report back to the Quality Assurance Committee.

Date of completion: March 24, 2014.

F 329 Drug regimen is free from unnecessary drugs

Corrective action for those affected: R10 has passed away since survey, but still reviewed resident record to identify missed dose reduction.

Identification of others having the potential to be affected: RN coordinator and DON audited resident record of other residents currently on anti-psychotic, antidepressants and anxiolytic medications to identify past medication reductions.

Measures to ensure the practice will not recur: MDS nurse implemented new tracking tool which includes last medication reduction. The care plan will list specific diagnosis with behavior warranting use of medication. Target behavior flow sheet will also identify these behaviors.

Monitoring: The MDS nurse or designee will review 10% of residents receiving anti-psychotic, anti-depressant and anxiolytic medications weekly to evaluate who had an attempted gradual dose reduction or justification for continued use of the medication at the current dose until compliance is reached and report back to the Quality Assurance Committee.

Date of completion: March 24, 2014.

F356 Posted nurse staffing information

Corrective action for those affected: New form was posted during survey immediately after discrepancy noted, including documentation of the actual hours worked by the licensed and unlicensed nursing staff.

Identification of others: Cokato Manor will post the specified information on a daily basis at the beginning day shift in a clear readable format and in a prominent place readily accessible to residents and visitors.

Measures to ensure the practice will not recur: New staffing form implemented which includes the facility name, census, current date, total number and the actual hours worked by the RN, LPN and NAR's directly responsible for resident care per shift. The facility will maintain the posted daily nurse staffing data for a minimum of 18 months.

Monitoring: The DON and HIS will monitor for correct information displayed on nurse staffing information and proper retention of the record monthly until compliance is reached and report back to the Quality Assurance Committee.

Date of completion: March 24, 2014.

F441 Infection control

Corrective action for those affected: Reviewed resident records for R32, R44, R70, R13 and R56 to identify tracking, trending and the surveillance of the facility outbreak of the gastrointestinal illness. Outbreak was reported to the Department of Health Gastrointestinal division during survey.

Identification of others having the potential to be affected: Reviewed all resident progress notes that were residing in the facility at the time of the outbreak and facility infection control log.

Measures to ensure practice will not recur: Updated facility policy and procedure on infection control to include components related to tracking, trending and surveillance of resident infections and outbreaks. Updated staff and resident tracking forms to include information regarding symptoms, dates of illness, location and staff interaction. Provided staff education on the importance of isolating resident for 24 hours after last symptom to prevent the spread of infection.

Monitoring: DON or designee will monitor residents symptoms, dates of illness, trends, location and employee contact weekly until compliance is reached and report back any correlation with resident and staff illness to the Quality Assurance Committee.

Date of completion: March 24, 2014.

Tricia Moffett LNHA 3-21-14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245412	A. BUILDING ______ MAR 17 2014 B. WING ______ MN Dept of Health St. Cloud	02/13/2014

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 A standard recertification survey was conducted and a complaint investigation(s) had also been completed at the time of the standard survey. An investigation of complaint H5412010 had not been substantiated during this survey. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in	F 157 3/24/14 [illegible] accepted.	See attached document	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] RN
TITLE: DON
(X6) DATE: 3.14.14

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

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F 157	Continued From page 1 §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician for high blood glucose levels, according to the physician orders, for 1 of 2 residents (R55) reviewed with elevated blood sugars. Findings include: R55 quarterly minimum data set (MDS) dated 10/24/13, indicated she had moderate cognitive impairment, had diagnoses of diabetes mellitus and received insulin. R55's current care plan dated 1/17/14 indicated R55 had a recent left foot amputation and a pressure ulcer on her right foot. R55's physician orders from 1/11/14 to 1/30/14 included: Lantus (insulin) 100 unit/ml (milliliter) 28 units sq (subcutaneous) before bedtime Novolog (insulin aspart) solution 100 unit/ml sliding scale for injection of blood glucose	F 157		

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F 157	Continued From page 2 121-150=0units, 151-200=1unit, 201-250=2units, 251-300=3units, 301-350=4units, greater than 350=5units notify medical doctor (MD). Glucometer checks before meal and at bedtime. Review of the Blood Sugars Administration History from 1/11/14 to 1/30/14 indicated the following: 1/13/14 blood sugar 388 1/20/14 blood sugar 357 1/22/14 blood sugar 425 1/24/14 blood sugar 446 1/27/14 blood sugar 464 1/28/14 blood sugar 467 Review of the facility progress notes and fax transmission forms from 1/11 through 1/29/14 indicated the physician was never notified of these elevated blood sugars until 1/29/14 when a fax with blood sugars was sent to the physician. The 1/29/14 fax identified the physician discontinued the Lantus insulin and ordered a sliding scale Novolog (insulin aspart) solution 100 unit/ml sliding scale for injection of blood glucose 121-150=2units, 151-200=4unit, 201-250=6units, 251-300=8units, 301-350=10units. There was no indication of what to do when the blood sugar was over 350. During observation and interview on 2/11/14, at 12:47 p.m, registered nurse (RN)-A was observed to give R55 Novolog insulin 6units. RN-A stated R55's blood sugar was 218 and she should have given R55 her insulin before she eat but was busy and couldn't give it to her until after she was done eating. The Blood Sugars Administration history indicated on 2/11/14, at 5:00 p.m. R55's blood sugar was	F 157		

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F 157	Continued From page 3 444. There was no indication the physician was notified of the high blood sugar. During interview 2/12/14, at 9:33 a.m. with the director of nursing (DON) stated the facility does not have a policy for notifying the physician of high or low blood sugars. The DON then stated the facility could tighten up on there procedure of notifying the physician of elevated or low blood sugars.	F 157		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide necessary services related to diabetic monitoring for 1 of 2 residents (R55) reviewed who had elevated blood sugars. Findings include: R55 quarterly minimum data set (MDS) dated 10/24/13, indicated she had moderate cognitive impairment, had diagnoses of diabetes mellitus and received insulin. R55's current care plan dated 1/17/14 indicated R55 had a left foot amputation and a pressure ulcer on her right foot.	F 309		

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F 309	Continued From page 4 R55's physician orders from 1/11/14 to 1/30/14 included: Lantus (insulin) 100 unit/ml (milliliter) 28 units sq (subcutaneous) before bedtime Novolog (insulin aspart) solution 100 unit/ml sliding scale for injection of blood glucose 121-150=0units, 151-200=1unit, 201-250=2units, 251-300=3units, 301-350=4units, greater than 350=5units notify medical doctor (MD). Glucometer checks before meal and at bedtime. Review of the Blood Sugars Administration History from 1/11/14 to 1/30/14 indicated the following: 1/13/14 blood sugar 388 1/20/14 blood sugar 357 1/22/14 blood sugar 425 1/24/14 blood sugar 446 1/27/14 blood sugar 464 1/28/14 blood sugar 467 Review of the facility progress notes and fax transmission forms from 1/11/14 to 1/30/14 indicated the physician was not notified of these elevated blood sugars until 1/29/14 when a fax with blood sugars was sent to him. The physician then ordered to discontinue the Lantus and ordered a sliding scale Novolog (insulin aspart) solution 100 unit/ml sliding scale for injection of blood glucose 121-150=2units, 151-200=4unit, 201-250=6units, 251-300=8units, 301-350=10units. The physician did not address what to do if the blood sugar was above 350. During observation and interview on 2/11/14, at 12:47 p.m, registered nurse (RN)-A was observed to give R55 Novolog insulin 6units. RN-A stated R55's blood sugar was 218 and she should have	F 309		

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F 309	Continued From page 5 given R55 her insulin before she eat but was busy and couldn't give it to her until after she was done eating. The Blood Sugars Administration history indicated on 2/11/14, at 5:00 p.m. R55's blood sugar was 444. There was no indication the physician was notified of the high blood sugar. During interview 2/12/14, at 9:33 a.m. with the director of nursing (DON) stated she was aware that R55 received her insulin after she ate and normally it should be given before meals. The DON also stated the staff did not notify the physician of R55's BS on 2/11/14 that was 444 because the facility received an order on 1/30/14 with a new sliding scale which did not indicate to notify the physician if the BS were greater than 350. She further stated the facility does not have a policy for notifying the physician of high or low blood sugars. The DON then stated the facility should tighten up on their procedure of notifying the physician with elevated or low blood sugars.	F 309		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325		

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F 325	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure adequate monitoring and individualized interventions were implemented to prevent weight loss for 1 of 3 residents (R17) investigated for weight loss. Findings include: R17's 30 day Minimum Data Set (MDS) dated 1/17/14 identified diagnoses that included dysphasia (difficulty swallowing), and paralysis. The MDS identified R17 had severe cognitive impairment, needs extensive assistance of one person for eating and needed extensive assistance with most activities of daily living (ADLs). R17's weights located on the vitals summary were: 1/12/14 139 pounds 2/10/14 133 pounds (These are the only weights available at time of survey.) The care plan dated 12/23/13 identified a problem with receiving mechanical soft diet and nectar thick liquids, with diagnosis of Parkinson's. Staff were directed to provide a mechanical soft diet and provide prompt and assistance as needed. The care plan also directed staff to "weigh weekly for one month, then monthly if stable." During observations on 2/12/14 at 8:00 p.m. R17 was at breakfast being prompted to eat, by an unidentified nursing assistant (NA) and consumed only bites of hot cereal, and sips of	F 325		

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F 325	Continued From page 7 coffee, and juice. At 12:40 p.m. R17 was eating his noon meal with verbal prompts, and consumed 100% of meat, 100 cc of soup, bites of vegetables and 20 cc of water and juice. The registered dietician (RD) progress note dated 1/15/14 indicated R17 "RD risk review for poor intake... nursing report poor intake and very slow...expect resident may benefit from a thickened supplement such as magic cup 4 oz bid [twice a day] to help compensate for poor intake. Will continue to monitor monthly per at risk policy." A fax to R17's physician dated 1/15/14 identified "resident intake poor/fair; eating very slowly; weight decreased; can we start magic cup [nutritional supplement] 4 oz bid for weight maintenance?" Physician responded "ok." Review of the medical record from 1/15/14 thru 2/12/14, did not identify if R17 was receiving his nutritional supplement "magic cup" or how much he was consuming on a daily basis to assist with his identified weight loss. During an interview on 2/11/14 at 3:19 p.m. Cook (C)-A indicates R17 has not been getting any nutritional supplement, they were not aware R17 was suppose to get these supplements. During an interview on 2/11/14 at 3:20 p.m. licensed practical nurse (LPN)-A stated she was not sure who was responsible for monitoring nutritional supplements and how much each resident consumed. During interview on 2/11/14 at 3:23 p.m. Certified Dietary Manager (CDM) stated she was not	F 325		

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F 325	Continued From page 8 aware of R17 had a order to receive the magic cup nutritional supplement related to his weight loss. CDM verified a physician order along with the dietician recommendation were written on 1/15/14 for the nutritional supplement to prevent further weight loss. During an interview on 2/13/14 at 11:12 a.m. the DON stated the CDM was responsible for all nutritional assessments, monitoring of weights and resident intake. There was a communication breakdown between nursing and dietary, and R17 should have received his nutritional supplement. During a telephone interview on 2/28/14 at 3:25 p.m. with RD stated, she was not aware R17 was not receiving his nutritional supplement, and should have been. "It does look like he slipped through the cracks." A facility policy regarding nutritional support for residents was requested but not provided.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329		

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F 329	Continued From page 9 given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 5 residents, (R10), who received antipsychotic medications had an attempted gradual dose reduction or justification for continued use of the medication at the current dose. Findings include: R10 Quarterly Minimum data set (MDS) dated 1/14/14 identified R10 had severe cognitive impairment, no delusions or hallucinations in the prior 7 day look back period, and required extensive assistance with all activities of daily living (ADLs). On 2/11/14 at 11:45 a.m. R10 was observed in the dining room eating lunch with three other residents at the table. The resident had no observed behaviors. On 2/12/14 at 8:05 a.m. R10 was observed sitting in the wheelchair in the cafe area. The resident had no observed behaviors.	F 329		

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F 329	Continued From page 10 Review of R10 current Physician order Report dated 2/13/14 identified the resident was taking the current medications: Zoloft 75 milligrams (mg) (antidepressant) at bedtime which was started on 1/15/13, for the diagnosis of depressive disorder. Seroquel 25 mg (antipsychotic) at bedtime starting on 2/28/13, for diagnosis of delusional disorder. Xanax 0.25 mg (antianxiety) twice a day beginning 1/15/13, for a diagnosis of anxiety state. Review of R10's care plan dated 2/11/14 identified the resident had behavioral symptoms related to psychosocial well being and difficulty related to behavior problem in dealing with people and coping, being outside of room in facility, with a history of depression, anxiety, and delusions. The approach's identified on the care plan included monitor for a pattern to the behavior manifestations, intensity, duration, and frequency. The care plan did not identify what specific behavioral symptoms were being monitored for the use of Zoloft, Seroquel, and Xanax. R10's Target Behavior Monitoring forms identified the following: October 2013 the target behavior(s) were listed together as "Delusions/ Inappropriate sexual acts/ fear of husband." The facility identified the resident had 31 episodes of these behaviors, 25 of them being on the day shift on 10/31/13. However, there was no indication of what the specific behavior R10 was presenting during this time frame, nor which specific medication was being used for these behaviors.	F 329		

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F 329	Continued From page 11	F 329		

November 2013 the target behavior(s) the facility was monitoring for R10 were listed separately as "fear of deceased husband and delusions of inappropriate sexual acts." There were no episodes of these behaviors occurring during November.

December 2013 the target behavior(s) were listed separately as "fear of deceased husband and delusions of inappropriate sexual acts." There were no episodes of these behaviors occurring.

January 2014 the target behavior(s) were listed separately as "fear of deceased husband and delusions of inappropriate sexual acts." The facility identified the resident had no episodes of of these behaviors occurring.

February 2014 the target behavior(s) were listed separately as "fear of deceased husband and delusions of inappropriate sexual acts." The facility identified the resident had not displayed any of these behaviors, to current review date of 2/12/14.

The facility Psychoactive Medication Quarterly Evaluation dated 1/14/14 identified R10 was currently taking Zoloft 75 mg, Xanax 0.25 mg BID, and Seroquel 25 mg for delusional disorder, anxiety, and depression. The behavior was identified as, "Signs and symptoms of appearing down, depressed, or hopeless and being short tempered, easily annoyed 2-6 days out of 14 days. Delusions 2x this quarter which resisted redirection..." The facility did not identify which specific medication was for which behavior.

R10's most recent Progress Note from the

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(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 329	Continued From page 12 Associated Clinic of Psychology dated 5/16/13 indicated, "...has severe signs and symptoms of cognitive impairment and is not a reliable reporter. Staff report that she generally eats adequately and sleeps but does engage in mood incongruent delusions and anxiousness that are sometimes hard to redirect. She continues to be prescribed Xanax 0.25 mg BID (twice a day), Zoloft 75 mg, and Seroquel 25 mg which do appear to be effective in managing behaviors and mood incongruent delusions... Pharmacological strategies are most likely of value and should be continued and possibly her Seroquel even increased subject to the distress being presented. This will be deferred to her primary care physician. Also, distributing her medications differently might be helpful... She is most likely not depressed and is expressing more behaviors secondary to dementia." Although the Psychologist indicated on 5/16/13 R10's medication management would be deferred to the residents primary physician. There was no indication the facility addressed the continued use of Xanax or Zoloft at the current dose, nor did the facility ensure the residents Seroquel was reviewed to determine if R10 was receiving the appropriate dose or the medication had justification for the continued use for R10. During interview on 2/13/14 at 10:00 a.m. registered nurse (RN)-A stated R10 had gotten very anxious and fearful in the past related to delusions. RN-A verified there had been no attempted dose reductions of the Seroquel 25 mg since it had been started over a year ago nor was there any specific behaviors identified for the continued use. RN-A verified the last time R10 had been seen by the psychologist was on	F 329		

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	245412	A. BUILDING _____ B. WING _____	02/13/2014

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F 329	Continued From page 13 5/16/13, and the medication management had been referred to the primary physician. However, there was no indication from the primary physician regarding the recommendation for continuing the medication nor to attempt a dose reduction. RN-A verified the behavior monitoring or the progress notes did not identify R10 was having any behaviors, however, she stated that staff may not always be marking the behavior monitoring appropriately. RN-A verified R10 had a significant decline related to dementia and health conditions in the past 6-8 months, however, the facility still did not reassess the possible dose reduction for the Seroquel. During interview on 2/13/14 at 10:20 a.m., licensed practical nurse (LPN)-A stated R10 has not had any behaviors of delusions or sexual inappositeness for a "very long time." LPN-A stated she was not aware this had been a problem for R10 in the past. During interview on 2/13/14 at 10:30 a.m. nursing assistant (NA)-A stated R10 has not had any behaviors of delusions or sexual inappropriateness for "over 6 months." A policy on antipsychotic dose reduction was requested but not provided.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and	F 356		

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F 356	Continued From page 14 unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post the required actual hours worked by the nursing staff in the facility, and keep past staff postings. This had the potential to affect all 45 residents in the facility and visitors. Findings include: During observation on 2/13/14, at 9:00 a.m. the Cokato Manor Report of Nursing Staff Directly Responsible for Resident Care posting dated	F 356		

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F 356	Continued From page 15 2/13/14, was observed next to the director of nursing (DON) office on the wall. The form identified the number of licensed staff including registered nurses and licensed practical nurses and unlicensed nursing staff including nursing assistance and trained medical assistance, total number of hours each worked and identified the shift as days, evenings and nights. The posting however lacked, documentation of the actual hours worked by the licensed and unlicensed nursing staff. During interview 2/13/14, at 9:30 a.m. the nursing services clerk verified the actual hours were not posted and stated she was not aware the posting was to include the actual hours worked. When request to review past postings she stated she does not keep them and was not aware she should have.	F 356		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		

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F 441	Continued From page 16 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the infection Control program included components related to tracking, trending, and surveillance of resident infections. In addition, the facility failed to ensure 5 of 5 residents, (R32), (R44), (R70), (R13), and (R56) who were reviewed that demonstrated symptoms of a infectious illness during a facility outbreak of a gastrointestinal (GI) illness were isolated while demonstrating symptoms. This had the potential to effect all 44 residents currently residing in the facility. Findings include: During review of the resident infection control log	F 441		

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F 441	Continued From page 17 for December 2013 identified two resident respiratory infections treated with antibiotics. The infections did not include symptoms, microorganisms, resident location or room numbers, and if the infection resolved. The December 2013 log also included two skin infections and one "other" infection. The antibiotic was identified, however, there were no symptoms, microorganisms, resident location or room numbers, and if the infection resolved. The infection identified as "other" was not identified as what type of infection this was. R32 had GI symptoms and was not isolated to prevent possible spread of infection. R32 quarterly Minimum Data Set (MDS) dated 1/2/14, indicated she was moderately cognitively impaired and needed assist with adl's and needs supervision with eating. Review of R32's progress notes dated 12/27/13, at 1:11 p.m. indicated "resident c/o not feeling well this morning. Emesis x1 medium amount, bile color... Loose stool x 1. " the note further indicated she had a temperature of 100.3 and received Tylenol 650 mg (milligrams) and R32 was complaining of feeling sick. Progress note dated indicated on 12/31/13, at 1:46 p.m. "Resident was sitting in recliner this morning. When staff member went into room to assist with daily ADL's, resident requested to stay in her room. A room tray was brought to her room for both breakfast and lunch. After breakfast, resident requested to lay in her bed for her air boots to be put on. She was in bed from 9:30 a.m.-10:30 a.m., then requested to get dressed. Writer assisted her with ADL's and	F 441		

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F 441	Continued From page 18	F 441		

assisted her into her wheelchair. Resident requested to sit in the front lobby, then go to the dining room. While she was in the dining room, she requested to go back to her room due to an upset stomach. A room tray was brought to her room. She also complained of feeling tired...".

Although R32 had GI symptoms the facility did not attempt to prevent R32 from potentially spreading a possible infection.

R44 had GI symptoms and was not isolated to prevent possible spread of infection.

R44 admission MDS dated 1/3/14, indicated she was cognitively intact, needed assist with adl's and supervision with eating.

Review of R44's progress notes indicated on 1/07/14 at 12:42 p.m., R44 "had loose stools this shift. Requested immodium this am and at 12 n [noon], which was given. Received shower this am. Anxious at times. Needs reassurance. Also became weepy at 12 n. States she misses her old friends. Resident has been down for all meals and eating adequately. Was sleepy mid am...".

Although R44 had GI symptoms the facility did not attempt to isolate her to prevent the possible spread of infection. R44 was not included on the highlighted list of residents who were displaying gastrointestinal symptoms in December 2013.

R56 had GI symptoms and was not isolated to prevent possible spread of infection.

R56 quarterly MDS dated 11/22/13 identified the

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F 441	Continued From page 19 resident had severe cognitive impairment and required extensive assistance with all ADL's. Review of R56's Resident Progress Notes indicated the following: 12/21/13 1:59 a.m.- "Has had 2 emesis and a large loose incontinent BM (bowel movement)... was brought to day room and put in recliner." 12/21/13 7:24 a.m.- "Has been sleeping in recliner in day room. Has had 4-5 more emesis..." Although R56 had vomiting and loose stools, the facility failed to ensure the resident was not out in common areas to prevent the spread of infection. R70 had GI symptoms and was not isolated to prevent possible spread of infection. R70 quarterly MDS dated 1/3/14 identified the resident was cognitively intact and was independent in ADL's. Review of R70's Resident Progress Notes indicated the following: 12/21/13 at 3:50 p.m.- "Has had emesis and loose stools during day shift. Resting in bed now. Clear liquids for diet..." 12/21/13 at 10:51 p.m.- "Clear liquids for supper. Had elevated temperature. Tylenol was given which was effective... up walking in halls." 12/22/13 2:31 p.m.- "Resident still complaining of upset stomach... ate breakfast in dining room..." Although R70 had vomiting and loose stools, the facility failed to ensure the resident was not out in common areas to prevent the spread of infection.	F 441		

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F 441	Continued From page 20 During interview on 2/11/14 at 12:50 p.m. the director of nursing (DON) stated she was in charge of the infection control program for the facility. The DON stated if a resident had an infection and was started on an antibiotic, that information was entered on the monthly infection control tracking sheet. The DON stated the facility tracked antibiotic use, the type of infection (skin, GI, respiratory, etc), and the date the antibiotic was started. The facility tracking did not include possible type of organism, symptom of infections, patterns or clusters of infections including wing location, and possible staff or environmental factors related to the organisms. The DON stated she "knows" what symptoms resident are having, but does not track them unless there is a trend noted in the facility. The DON stated the facility had a gastrointestinal virus out break in December 2013, however, there was no tracking or trending of the outbreak which included symptoms and/ or dates. The DON provided a printed list of all of the residents residing in the facility with a date of December 2013. The list had 14 resident names highlighted. The DON stated the residents highlighted were the residents that displayed symptoms of the gastrointestinal illness in December 2013. The DON verified the highlighted resident names did not provide any information about symptoms, dates of illness, or analysis of trends related to wings, rooms, or employee contact. The DON provided a log of employee gastrointestinal illness in December 2013. The employee illness log identified 43 staff displayed gastrointestinal illness symptoms in December 2013, however, there was no analysis regarding correlation with residents illness, nor was there evidence of re-education for the staff regarding infection control. The DON stated the	F 441		

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F 441	Continued From page 21 gastrointestinal outbreak was not reported to the state as required. The DON stated the facility did not have a policy regarding the infection control program.	F 441		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. 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 not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	POC ok KB 3-26-14 RECEIVED MAR 24 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Dc: 3-25-14

EXIT: 3-13-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	DON	3.14.14

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

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	245412	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/13/2014**

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K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Cokato Manor is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1964 and was determined to be of Type II(111) construction. In 1995, an addition was constructed to the east wing and was determined to be of Type II(111) construction. Another addition was added in 1999 to the south wing and was determined to be Type II (111). Because the original building and the 2 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 56 beds and had a census of 43 at time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations, the facility has failed to provide proper protection from 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. The following deficient practice could negatively affect the residents, staff, and visitors as smoke and fire in this rooms could enter the corridor making it untenable. Findings include: On facility tour between 10:00 AM to 1:00 PM on 02/13/2014, observation revealed, that the door to the utility room #117 did not completely close and positively latch into the frame.	K 029	2-18-14	

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K 029	Continued From page 3 This deficient practice was verified by the Maintenance Supervisor (SS).	K 029		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect all residents, visitors and staff of the facility. Findings include: On facility tour between 10:00 AM to 1:00 PM on 02/13/2014, observations reveled that the spare	K 056	2-20-14	

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K 056	Continued From page 4 sprinkler head box was not equipped with at least 2 of every type and style of sprinkler heads that are being used in the facility. The observed missing spare sprinkler heads were the QR/EC heads like the ones located in the resident rooms. This deficient practice was verified by the Maintenance Supervisor (SS).	K 056		

K 029 The door handle has been replaced on door entering room #117. All other doors in the facility with self-closing devices were inspected to ensure that they positively latched and closed properly. Completed on 2/18/2014.

K 056 Additional sprinkler heads were obtained from Sentry Fire Protection and placed in sprinkler head box. Completed on 2/20/2014.