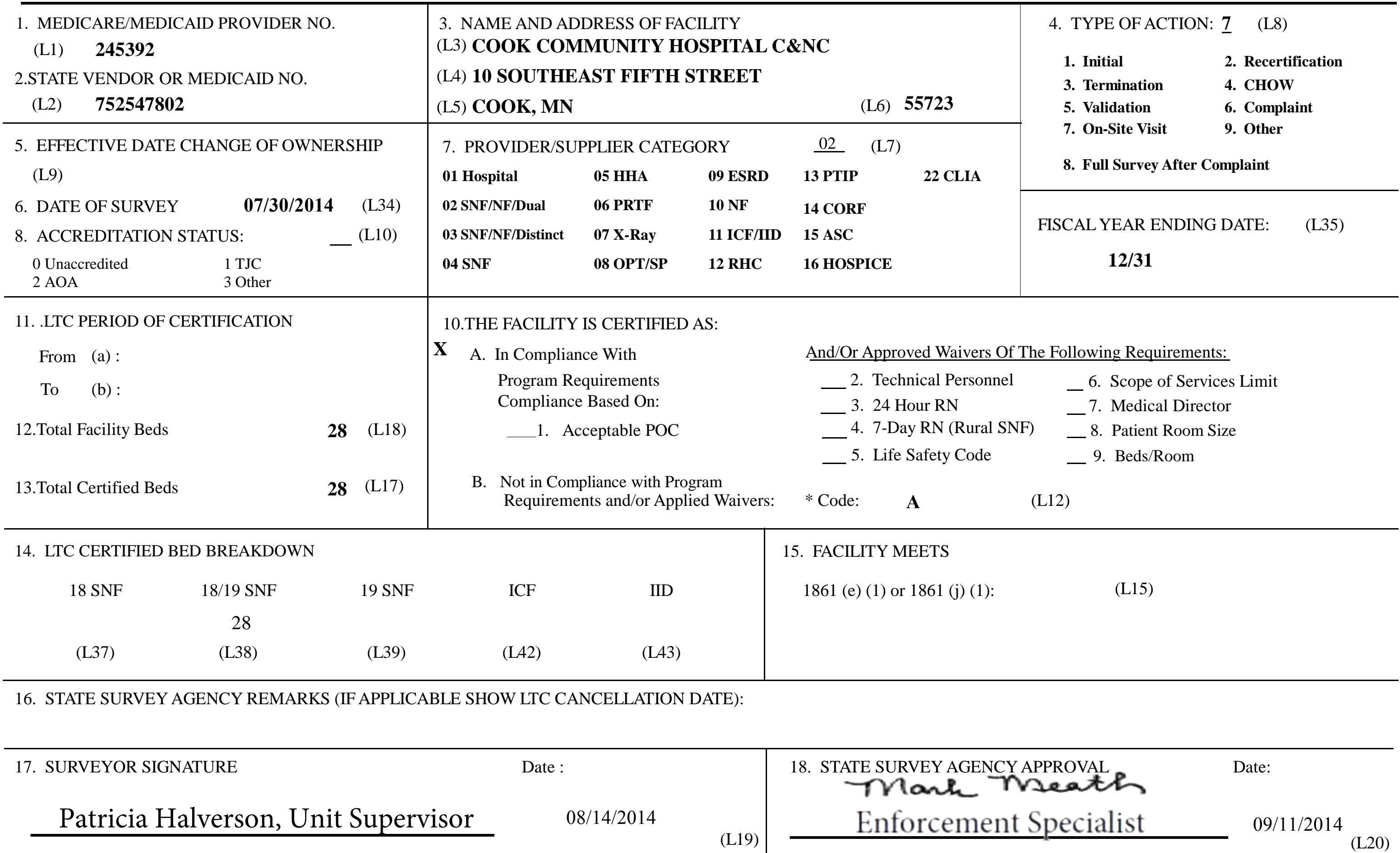
DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID: GDZF
Facility ID: 00586



1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245392**
2. STATE VENDOR OR MEDICAID NO. (L2) **752547802**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **07/30/2014** (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) **12/31**

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

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Patricia Halverson, Unit Supervisor 08/14/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 09/11/2014 (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 **12/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS
Posted 09/24/2014 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **08/04/2014** (L33)

DETERMINATION APPROVAL

*Protecting, Maintaining and Improving the Health of Minnesotans*

CMS Certification Number (CCN): 24-5392

August 11, 2014

Mr. Allen Vogt, Administrator
Cook Community Hospital C&NC
10 Southeast Fifth Street
Cook, Minnesota 55723

Dear Mr. Vogt:

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 July 20, 2014 the above facility is certified for:

28 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

cc: Licensing and Certification File

*Protecting, Maintaining and Improving the Health of Minnesotans*

August 11, 2014

Mr. Allen Vogt, Administrator
Cook Community Hospital C&NC
10 Southeast Fifth Street
Cook, Minnesota 55723

RE: Project Number S5392024

Dear Mr. Vogt:

On June 18, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 5, 2014. 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 July 25, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 18, 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 June 5, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 21, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 5, 2014, effective July 20, 2014 and therefore remedies outlined in our letter to you dated June 18, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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

cc: Licensing and Certification File 5392r14

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 |
|---|---|---|
| 245392 | A. Building<br>B. Wing | 7/25/2014 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| COOK COMMUNITY HOSPITAL C&NC | 10 SOUTHEAST FIFTH STREET<br>COOK, MN 55723 |

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

| (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed |
|---|---|---|---|---|---|
| ID Prefix **F0164**<br>Reg. # **483.10(e), 483.75(l)(4)**<br>LSC | **07/20/2014** | ID Prefix **F0221**<br>Reg. # **483.13(a)**<br>LSC | **07/20/2014** | ID Prefix **F0279**<br>Reg. # **483.20(d), 483.20(k)(1)**<br>LSC | **07/20/2014** |
| ID Prefix **F0280**<br>Reg. # **483.20(d)(3), 483.10(k)(2)**<br>LSC | **07/20/2014** | ID Prefix **F0282**<br>Reg. # **483.20(k)(3)(ii)**<br>LSC | **07/20/2014** | ID Prefix **F0309**<br>Reg. # **483.25**<br>LSC | **07/20/2014** |
| ID Prefix **F0312**<br>Reg. # **483.25(a)(3)**<br>LSC | **07/20/2014** | ID Prefix **F0465**<br>Reg. # **483.70(h)**<br>LSC | **07/20/2014** | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |

| Reviewed By | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| State Agency | PHL/mm | 08/11/2014 | 12835 | 07/25/2014 |
| CMS RO | | | | |

| Followup to Survey Completed on: | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? | YES | NO |
|---|---|---|---|
| 6/5/2014 | | | |

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 |
|---|---|---|
| 245392 | A. Building B. Wing 01 - MAIN BUILDING 01 | 7/18/2014 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| COOK COMMUNITY HOSPITAL C&NC | 10 SOUTHEAST FIFTH STREET<br>COOK, MN 55723 |

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

| (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|---|---|---|---|---|---|
| ID Prefix<br>Reg. # NFPA 101<br>LSC K0050 | Correction Completed 06/11/2014 | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
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| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| Reviewed By State Agency | Reviewed By PS/mm | Date: 08/11/2014 | Signature of Surveyor: 03005 | Date: 07/18/2014 |
|---|---|---|---|---|
| Reviewed By CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |
| Followup to Survey Completed on: 6/3/2014 | | 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**

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY**

ID: GDZF
Facility ID: 00586

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **06/05/2014** (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) **12/31**

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Teresa Ament, HFE NEII 07/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 08/04/2014 (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 **12/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS
Posted 08/04/2014 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

*Protecting, Maintaining and Improving the Health of Minnesotans*

Certified Mail # 7013 2250 0001 6357 1515

June 18, 2014

Mr. Allen Vogt, Administrator
Cook Community Hospital C&NC
10 Southeast Fifth Street
Cook, Minnesota 55723

RE: Project Number S5392024

Dear Mr. Vogt:

On June 5, 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.

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:

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

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

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

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

**DEPARTMENT CONTACT**

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

**Patricia Halverson, Unit Supervisor**
**Duluth Technology Village**
**11 East Superior Street, Suite 290**
**Duluth, Minnesota 55802-2007**

**Telephone: (218) 302-6151**
**Fax: (218) 723-2359**

**OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 15, 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 July 15, 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 September 5, 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 December 5, 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.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118    Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File    5392s14.rtf

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 |
|---|---|---|---|
| | 245392 | A. BUILDING ______ RECEIVED<br>B. WING ______ JUL 01 2014 | 06/05/2014 |

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

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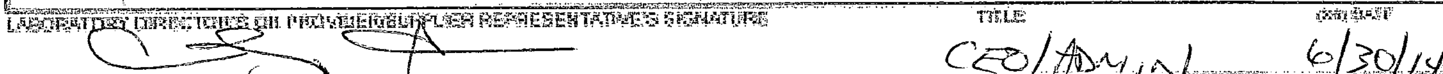
| F 000 | INITIAL COMMENTS<br><br>THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>UPON RECEIPT OF AN ACCEPTABLE POC, 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.<br><br>Census 26 | F 000 | Responsible party to ensure the corrections stated herein have been completed or will be completed on assigned dates:<br><br>Julie Gerzin, RN/DON-NH<br><br>Per phone conversation with Al Vogt, administrator, on 7/2/14 - all correction dates should be 7/20/14 PLH | |
| F 164 SS=D | 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS<br><br>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.<br><br>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.<br><br>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.<br><br>The resident's right to refuse release of personal and clinical records does not apply when the | F 164<br><br>7-7-14 GPN/P.H. | | 7/20/14 |



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO/ADMIN — (X6) DATE: 6/30/14

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 164 Continued From page 1

resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and document review, the facility failed to provide privacy during blood glucose monitoring and/or insulin administration for 2 of 2 residents (R20, R30) whose diabetic procedures and medication administration were observed.

Findings include:

On 6/4/14, at 11:08 a.m. during the medication administration observation registered nurse (RN)-A was observed to perform a blood glucose monitoring procedure with R20 in the facility's day/activity room. Several other residents along with several visitors were observed to be seated in the day/activity room. R20 was observed to be wrapped in a white blanket and was noted to barely verbally or physically respond to RN-A as RN-A poked R20's fourth finger on the left hand and applied a drop of R20's blood to a strip in the blood glucose monitor. After R20's blood glucose monitoring procedure was completed, RN-A was observed to return to R20 and injected the insulin in the back R20's left upper arm.

An electronic Diagnosis Summary dated 5/16/14,

F 164

F164: It is the policy of the Cook Hospital and Nursing Home to provide privacy for all residents when treatment is administered such as insulin or blood glucose monitoring.

The Nursing Home policy titled "Privacy and Confidentiality" (**see attachment A**) was updated on 6/27/14 and reads as follows :

Treatment Privacy: Staff will insure that residents and patients shall have the right to respectfulness and privacy as it relates to their medical and personal care program. When administering treatment such as : Blood glucose monitoring, insulin administration staff will ask resident if they would like to go to a private area. If the resident wants the treatment administered in a common area, the expectation is that staff also will ask those residents around the individual receiving the treatment if it is okay to administer or perform the treatment in their presence.

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| F 164 | Continued From page 2<br>indicated R20's diagnoses included diabetes mellitus type 2.<br><br>On 6/4/14, at 11:37 a.m. RN-A was observed to approach R30 with a prepared blood glucose monitor. R30 was seated at the table in the day/activity room. Many other residents were seated at the table. RN-A was observed to poke a finger on R30's left hand and applied a drop of R20's blood to the prepared blood glucose monitor.<br><br>An electronic Diagnosis Summary dated 5/30/14, indicated R30's diagnoses included diabetes mellitus type 2.<br><br>On 6/4/14, at 1:40 p.m. RN-A stated she usually does the blood glucose monitoring procedure and the insulin administration in the common areas of the facility. RN-A further stated she would usually ask the resident if it is alright to do the blood glucose monitoring procedure and insulin administration while others are present in the day/activity room and she normally asks the other residents who are present, if they are alright with doing procedures in the common areas. RN-A stated she did ask R20 and R30 if they were comfortable with receiving the procedures in the common areas, but did not provide for their privacy or ask the other residents if they were comfortable with either R20 or R30 receiving the blood glucose monitoring and/or the insulin administration.<br><br>On 6/5/14, at 9:00 a.m. R20 was observed to be seated in the dining room of the facility. RN-B was observed to approach R20 and then administer insulin in the back of R20's left upper arm. R20's table-mate along with several other | F 164 | F164 (cont.)<br><br>Ongoing audits/monitoring will be performed throughout the next 2 months and intermittently after such time by the DON and/or MDS Coordinator to insure compliance with treatments and privacy.<br><br>DON will record results of audits through QAPI.<br><br>RN/LPN staff in the NH will be re-educated in regards to updated policy on 6/27/14. Licensed staff not present will review and sign the new policy on the next scheduled shift worked.<br><br>In addition all future Licensed staff will be educated upon hire. | |

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| F 164 | Continued From page 3<br>residents were noted to be present in the dining room eating breakfast.<br><br>On 6/5/14, at 9:42 a.m. RN-B stated she usually does the insulin administration in the common areas of the facility, such as the dining room, when other residents are present. RN-B further stated she normally asks the resident if they are alright with receiving the insulin injection, but does not always ask the other residents present if they are alright with the insulin injection taking place in a public location, unless she knows they are squeamish.<br><br>On 6/5/14, at 10:45 a.m. the director of nursing (DON) stated the topic of performing blood glucose monitoring procedures and the administration of insulin had been brought up when she was in charge of risk management. The DON further stated most of the residents when asked to go to a private location for these procedures have told the nurses to just do the procedure or administer the insulin right here. The DON confirmed the residents should be asked if they want more privacy during these types of procedures and the nurses should be providing for that privacy.<br><br>A privacy policy was requested, but none was provided. | F 164 | | |
| F 221 SS=D | 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS<br><br>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. | F 221 | | 7-20-14 |

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F 221 Continued From page 4

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility did not ensure 1 of 1 resident (R1) reviewed for restraints was assessed for the safe and continued use of a lap belt restraint. In addition, the facility did not ensure clinical indications for the use of the restraint.

Findings include:

R1's diagnoses listed on the History and Physical (H&P) dated 4/25/14 included dementia from Alzheimer's disease, a history of depression, rheumatoid arthritis and osteoporosis. The quarterly Minimum Data Set (MDS) dated 4/14/14, indicated R1 had severe cognitive impairment. R1 required the total assistance of two staff to transfer. R1 required the extensive assistance of two staff with bed mobility and toileting; was non ambulatory and used a trunk restraint in the wheelchair daily.

The Physical Restraint Care Area Assessment (CAA) dated 7/18/13, indicated R1 required the total assistance of two staff and the Hoyer (mechanical) lift with all transfers and required total assistance with locomotion in the "tilt" wheelchair. R1's last fall was in April 2012 when R1 slid down and out of the wheelchair. The daughter requested R1 wear the seat belt at all times when in the wheelchair.

The fall risk care plan dated 7/14/13, indicated R1's last fall was on 4/13/12. R1 was at risk for falls and would scoot down in the wheelchair to scratch her head by rubbing it against the back of the wheelchair. R1 needed a Velcro restraint belt.

F 221

F221 "Restraints-Assessments/Reductions" and is dated June 2014. **(see Attachment B)** This policy now includes detailed instruction including attached assessments on consent, pre-restraint assessment, ongoing physical restraint elimination review as well as the expectations as to the Restraint/Restorative Committee and documentation responsibilities in the resident record.

Policy revision now states," Resident will have a Pre-Restraining Assessment completed as well as an ongoing review for the elimination or reduction of a physical restraint". As well as describes in detail on pg. 2 the procedure to follow with initiation or ongoing evaluation of the physical restraint. "The informed consent for use of restraints form is reviewed in detail with the resident/family insuring benefits and risks are thoroughly explained and that the resident is in agreement. *the facility may NOT use a restraint solely based on a legal surrogate or representatives request. (cont)

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| F 221 | Continued From page 5<br>Approaches included a Velcro belt to help prevent sliding or scooting down in the wheelchair. The care plan directed staff to release the lap belt every two hours for 10 minutes, during meals and supervised activities. The family requested the lap belt be continued daily. R1 had had been observed removing the lap belt but was unable to open the belt upon request.<br><br>On 6/03/14 during the breakfast meal R1 was observed in the dining room in tilt wheelchair. Two white strap crossed in the back of the wheelchair and attached to the anti tip bars of the wheelchair. R1 was covered with a blanket and the straps were coming out from around R1. Observation of R1's wheelchair when when R1 was in bed displayed a Velcro strap that went across and connected with Velcro to the strap on the opposite side of the wheelchair.<br>On 6/4/15, during the breakfast and lunch meal staff was observed to open the lap belt while assisting R1 with eating. After both meals R1 returned to her room was put to bed. R1 was not observed to move herself, other then the arms, in the wheelchair.<br><br>On 6/5/14 at 10:55 a.m. the director of nursing (DON) stated R1 could open the lap belt but did not know if she could open the lap belt every time when asked. The DON stated R1 did not have a hip and in the past had trouble staying in the wheelchair. "But it has been awhile and now it looks like it is used per the family's request." The DON also stated the interdisciplinary team (IDT) met weekly and discussed restraints. The DON left a note that stated there was no consent for use of the restraint, the reduction plan was on the care plan, and it was unknown how long the lap belt had been in place. Family education on risks | F 221 | (cont) F221: Reduction has been added on page 3 to include the following, "The Physical Restraint Elimination Review form will be completed monthly and PRN by the Restraint/Restorative Committee. Alternatives will be trialed as identified through the Restraint/Restorative Committee in conjunction with the physician's recommendations as appropriate."<br><br>R1 will be reviewed on 7/1/14 for a potential reduction of restraint (Velcro lap belt) during the Restraint/Restorative Committee meeting.<br><br>Re-education of staff will be carried out in a mandatory meeting on 7/9/14 and will include the updated Restraint assessment/reduction policy, expectations for release and documentation. Employees whom are unable to attend will have the policy reviewed 1:1 by DON.<br><br>Future employees will receive restraint education during new hire orientation.(Cont.) | |

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| F 221 | Continued From page 6<br>and benefits, and restraint IDT meeting notes were not provided.<br><br>On 6/5/14, at 12:50 p.m. the occupational therapist (OT) was interviewed. The OT stated R1 has had the tilt wheelchair for a long time, "At least 5 years". R1 had the lap belt in the wheelchair before getting the tilt wheelchair. The lap belt was put on the new tilt wheelchair per the family's request. The OT stated restraints were reviewed weekly at the restraint/restorative meeting however R1's was not discussed as much because it was family requested.<br><br>The Restraint policy revised May 2005, indicated the resident had the right to be free from physical restraint imposed for purposes of discipline, convenience and not required to treat a resident's medical condition. The least restrictive device would be utilized. The purpose of the policy was to protect residents from injury due to a specific medical symptom and may be utilized as a measure to maintain the highest level of function. The policy indicated the care plan would include the restraint/device used and rationale, alternatives and reductions. A systematic and gradual process would initiate reduction of the restraints. The IDT would review the restraints every week. Assessments and what restraint device would be used would be determined by the IDT. | F 221 | F221 (cont.)<br><br>Restraint compliance with updated policy and procedure will be monitored X 3 months by DON through chart review, review of Restraint/Restorative Committee notes as well as placed as a QAPI to improve and monitor the process currently updated for Restraints with plan for ongoing auditing to be determined through QAPI findings. | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. | F 279 | | |

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| F 279 | Continued From page 7<br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure the care plan was developed for 1 of 5 residents (R28) receiving diuretics and insulin, and 1 of 5 residents (R4) receiving Coumadin.<br><br>Findings include:<br><br>R28's diagnoses from the summary list and medication list for May/2014, include diabetes, edema, hypertension, ascites, and anemia.<br><br>The Minimum Data Set (MDS) dated 5/28/14, indicated R28 was cognitively intact and required extensive assistance of one staff for bed mobility and dressing, extensive assistance of two staff for transfers and toileting, limited assistance of one staff for wheelchair locomotion and personal hygiene, and was independent with eating. The | F 279 | F279:<br><br>It is the policy of the Cook Hospital and Nursing Home to develop a Comprehensive Care Plan for each resident to include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs.<br><br>The "Care Plan Comprehensive-Nursing" policy **(See attachment C)** was revised on 6/27/14 to include "special considerations" in which it states, "the MDS Coordinator will review specific medications that residents are on and include signs/symptoms to monitor for in regards to the specific medication insuring that a problem statement, goal, indications and interventions are clearly stated. i.e. diuretics, Coumadin/warfarin/lovenox, and insulin.<br><br>MDS Coordinator was educated on the revised policy above on 6/27/14.<br><br>MDS Coordinator is reviewing all care plans to insure that these medications/signs symptoms, etc are | 7-20-14 |

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| F 279 | Continued From page 8<br>MDS further indicated R28 received insulin and a diuretic.<br><br>R28's signed physician orders of 4/15/14, directed Spironolactone (diuretic) 25 milligrams (mg) daily and Insulin (for diabetes) for R28. Signed physician orders of 5/19/14, directed Lasix 20 mg daily.<br><br>The medication administration record (MAR) dated May 2014, indicated R28 received insulin as ordered by the physician for diabetes, Spironolactone 25 mg BID and lasix (diuretic) 20 mg daily for hypertension.<br><br>R28's care plan dated 4/15/14 lacked a problem statement related to the use of insulin, a goal, and approaches related to the use of insulin; and lacked indications for use, goals or approaches for lasix or Spironolactone<br><br>During an interview on 6/5/14, at 12:45 p.m. the director of nursing (DON) verified the indications for use of the insulin and the diuretic, and the approaches for each should be addressed on the care plan.<br><br>The facility was unable to provide a policy and procedure for the development of care plans.<br><br>An electronic Summary - Diagnoses form dated 5/29/14, indicated R4's diagnoses included atrial fibrillation.<br><br>An annual MDS dated 4/6/14, indicated R4's Brief Interview for Mental Status (BIMS) score was 13, depicting R4 as cognitively intact. | F 279 | (F279 Cont.) Completion date assigned is July 13th, 2014.<br><br>Education of policy will be provided to all licensed nursing staff during mandatory meeting on 7/9/14. Staff unable to attend will receive 1:1 review with DON.<br><br>Newly hired licensed staff will receive education during orientation.<br><br>QAPI will be created by 7/15/14 with audits of care plans being completed by DON and MDS Coordinator x 3 months to insure accuracy. | |

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| F 279 | Continued From page 9<br>R4's Medication Administration Record [Physician's Orders] dated 5/19/14, indicated Coumadin po (orally) as directed. A monthly medication schedule dated 6/1/14, to 7/1/14, indicated R4 had been receiving Coumadin 7.5 mg by mouth daily.<br><br>Review of R4's Plan of Care (POC) last reviewed 4/16/14, indicated a lack of a problem, outcome or intervention to address the use of Coumadin.<br><br>R4 was observed throughout the survey week of 6/2/14, through 6/5/14.<br><br>On 6/5/14, at 9:46 a.m. registered nurse (RN)-B stated R4 had been receiving Coumadin daily. RN-B further stated any side effects from the Coumadin would be documented in the progress notes. RN-B confirmed R4's POC lacked a problem statement, an outcome and any interventions related to R4 receiving the Coumadin.<br><br>On 6/5/14, at 10:45 a.m, the DON stated the POC should include signs and symptoms of unusual bleeding and/or bruising when a resident is receiving Coumadin. | F 279 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the | F 280 | | 7-20-14 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245352 | A. BUILDING ______<br>B. WING ______ | 06/05/2014 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 280 | Continued From page 10<br>comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure the care plan was revised to ensure appropriate positioning for 1 of 2 residents (R13) reviewed for positioning.<br><br>Findings include:<br><br>R13's diagnoses per the diagnosis summary list provided on 6/4/14, included diabetes, Alzheimer's disease, polymyalgia rheumatica, glaucoma, osteoarthrosis, lumbosacral spondylosis, osteoporosis, longterm use of steroids, and abnormality of gait with history of falls.<br><br>The annual Minimum Data Set (MDS) dated 1/24/14, indicated R13 had severe cognitive impairments, required extensive assist of one staff for bed mobility, transfers, ambulation, locomotion in wheelchair, dressing, eating, toileting, personal hygiene, and bathing, was frequently incontinent of bladder and bowel, had severe pain frequently, and was at risk for skin | F 280 | F280:<br><br>It is the policy of Cook Hospital and Nursing Home that the Comprehensive Care Plan is consistent, accurate and is followed by all nursing staff. Current revised policy titled, " Care Plan Comprehensive- Nursing" was revised on 6/27/14 to include<br><br>MDS Coordinator educated on Care Plan Comprehensive- Nursing policy on 6/27/14.<br><br>A full review of all resident Care Plans is to be completed by goal date: 7/13/14 to insure accuracy and consistency between records.<br><br>Education of policy will be provided to all licensed nursing staff during mandatory meeting on 7/9/14. Staff unable to attend will receive 1:1 review with DON.All new employees will receive education<br><br>'MDS Coordinator educated on 6/27/14 that MDS must be consistent with Plan of Care.<br><br>(Cont.) | |

F 280 Continued From page 11
breakdown.

The pressure ulcer care area assessment (CAA) dated 1/31/14, indicated R13 required extensive assist with all ADLs, was able to turn self independently in bed, and had a pressure relief mattress in bed, stationary chair, and the wheelchair to aid in skin integrity. The CAA further indicated R13 was frequently incontinent of bowel and bladder. The nutrition CAA dated 1/29/14, indicated R13 was at increased risk for skin breakdown related to lower meal intake and weight.

Tissue tolerance testing performed on 4/19/14 and 4/20/14, indicated R13 tolerated being in the same position for two hours at a time while in bed and in the wheelchair.

The Nutrition Skin Risk Braden Assessment dated 4/28/14, indicated R13's nutritional status may place her at an increased risk for the development of pressure areas.

R13's care plan dated 7/12/13, indicated R13 was at risk for skin breakdown secondary to diabetes, impaired cognition, limited mobility, incontinence and directed staff to turn, reposition or offload R13 every two hours and as necessary. The care plan directed staff to toilet every 3 hours. The nursing assistant care sheets indicated R13 was independent with repositioning and directed staff to toilet her every two hours. This information was not consistent with the care plan.

On 6/4/14, at 1:43 p.m. RN-A said the repositioning time for R13 should be every two hours and verified the care sheet said R13 was

F 280

F280 (Cont.)

Education of policy will be provided to all licensed nursing staff during mandatory meeting on 7/9/14. Staff unable to attend will receive 1:1 review with DON.

QAPI will be added by 7/15/14 to include process improvement for consistency of Comprehensive Care Plan. This will provide ongoing monitoring by DON, MDS and QAPI team assigned.

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|---|---|---|---|
| | 245392 | A. BUILDING ______ B. WING ______ | 06/05/2014 |

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

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| F 280 | Continued From page 12<br>independent with repositioning and toileting was every two hours. RN-A stated she thought resident should be repositioned every 2 hours.<br><br>During an interview on 6/5/14, at 12:30 p.m. the director of nursing (DON)-B stated tissue tolerance tests are performed on each resident upon admission and with changes and the determination of the resident's needs and changes in R13's care should have been communicated by notifying staff in report, putting it in the care planning change book, emailing the nursing assistants and nurses with the change, staff was directed to check emails for changes daily, and updating the care plan and care sheets, which staff carry each shift they work. The DON verified the care plan directed staff to reposition R13 every two hours and the care sheets indicated the resident was independent with repositioning. The DON verified she expected the staff to reposition residents according to the care plan.<br><br>The facility policy and procedure for care plans dated 3/14, directed care plans to be kept and maintained in the electronic health record for each resident, staff to follow the care plans, staff to e-mail or leave a note for DON or the MDS coordinator if a care plan looks out of date or the information does not match what is currently being done for the resident. The policy and procedure further indicated the care plans were to be developed, updated and followed by the nursing staff and that all staff is knowledgeable of current care plans. | F 280 | | |
| F 282 SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN | F 282 | See page 15 for this tag response. | 7-21-14 |

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| F 282 | Continued From page 13 | F 282 | | |

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, oral care was not provided as directed by the care plan for for 1 of 3 residents (R13) reviewed for oral care.

Findings include:

R13's diagnosis summary list provided on 6/4/14 included diabetes, Alzheimer's disease, anemia, polymyalgia rheumatica, glaucoma, and osteoporosis.

The Minimum Data Set (MDS) dated 1/24/14, indicated R13 has a severe cognitive impairment and required extensive assistance of one staff for personal hygiene and bathing. The MDS indicated R13 had no impairments of range of motion and had a cavity or broken teeth. The dental care area assessment (CAA) dated 1/31/14, indicated R13 required extensive assistance with all activities of daily living (ADLs), answers yes or no questions, and has a few of her natural teeth that have cracked or fallen out.

The care plan dated 7/12/13, indicated R13 had decreased ability to perform self care activities, including brushing teeth. The care plan directed staff to set up supplies for oral cares and provide verbal cues for R13 to complete tasks. The nursing assistant care sheet dated 6/3/14, indicated R13 had her own teeth and directed

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|---|---|---|---|
| | 245392 | A. BUILDING ______<br>B. WING ______ | 06/05/2014 |

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| F 282 | Continued From page 14<br>staff to provide oral cares after each meal. The dental consultation dated 12/0/13, indicated R13 had a broken front tooth and twice daily oral hygiene was recommended.<br><br>Oral cares were not observed to be performed during continuous observations of R13 on 6/4/14, from 7:06 a.m. when R13 was seated in the wheelchair and dressed in the day room, through 9:55 a.m. R13 completed breakfast and was brought to the day room at 9:08 a.m. When R13 was brought to the bathroom at 9:55 a.m. by registered nurse (RN)-A and nursing assistant (NA)-B per surveyor's request, oral hygiene was not observed to be performed.<br><br>On 6/4/14, following lunch at 12:45 p.m. R13 was brought to the dayroom. At 1:20 p.m., NA-C stated that she only had R13 for morning cares and had not performed cares since then. On 6/4/14, at 1:25 p.m. NA-B stated she had not taken R13 to the bathroom or performed cares since 9:55 a.m.<br><br>On 6/5/14, at 12:30 p.m. the director of nursing (DON)-B verified that staff should have followed the care plan for oral hygiene.<br><br>The policy and procedure for care plans dated 3/14, directed all nursing staff to follow the care plan and to read and follow care plans as outlined. | F 282 | F282: It is the policy of Cook Hospital and Nursing Home that oral hygiene is provided to each resident as their care plan states. (Attachment H).<br><br>R13 will receive oral hygiene as stated in her care plan.<br><br>All staff will be re-educated to this policy on July 9, 2014.<br><br>QAPI will be developed by July 15, 2014 by DON in regards to oral hygiene and individualized care plans.<br><br>Newly hired staff will receive oral hygiene education in orientation. | |
| F 309<br>SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, | F 309 | | |

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| F 309 | Continued From page 15<br>mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, repositioning assistance was not provided as directed by the plan of care for 2 residents (R13) reviewed for repositioning.<br><br>Findings include:<br><br>R13's diagnoses per the diagnosis summary list provided on 6/4/14, included diabetes, Alzheimer's disease, polymyalgia rheumatica, glaucoma, osteoarthrosis, lumbosacral spondylosis, osteoporosis, longterm use of steroids, and abnormality of gait with history of falls.<br><br>The annual Minimum Data Set (MDS) dated 1/24/14, indicated R13 had severe cognitive impairments, required extensive assist of one staff for bed mobility, transfers, ambulation, locomotion in wheelchair, dressing, eating, toileting, personal hygiene, and bathing, was frequently incontinent of bladder and bowel, had severe pain frequently, and was at risk for skin breakdown.<br><br>The pressure ulcer care area assessment (CAA) dated 1/31/14, indicated R13 required extensive assist with all ADLs, was able to turn self independently in bed, and had a pressure relief mattress in bed, stationary chair, and the wheelchair to aid in skin integrity. The CAA | F 309 | F309: It is the policy of Cook Hospital and Nursing Home that residents will receive all care as identified in their specific Comprehensive Care Plan. (Attachment C).<br><br>R13 Requires assistance with repositioning and toileting every 2 hours and PRN. The care plan and care sheet are consistent with information at this time. MDS Coordinator has implemented a Care Kardex sheet as of June 26th, 2014 to insure consistency is improving. This process will be monitored through QAPI as created by the DON and MDS Coordinator.<br><br>DON will provide a mandatory inservice to all nursing staff on July 9th, 2014 to re-educated in regards to duties and expectations including repositioning and following the Plan of Care as written.<br><br>QAPI will be developed by July 15th, 2014 by DON in regards to cares including toileting and repositioning. Audits and plan | 7-20-14 |

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| F 309 | Continued From page 16<br>further indicated R13 was frequently incontinent of bowel and bladder. The nutrition CAA dated 1/29/14, indicated R13 was at increased risk for skin breakdown related to lower meal intake and weight.<br><br>Tissue tolerance testing performed on 4/19/14 and 4/20/14, indicated R13 tolerated being in the same position for two hours at a time while in bed and in the wheelchair.<br><br>The Nutrition Skin Risk Braden Assessment dated 4/28/14, indicated R13's nutritional status may place her at an increased risk for the development of pressure areas.<br><br>The care plan dated 7/12/13, indicated R13 was at risk for skin breakdown secondary to diabetes, impaired cognition, limited mobility and incontinence. The care plan directed turn, reposition or offload R13 every two hours and as necessary.<br><br>The nursing assistant care sheets indicated R13 was independent with repositioning and directed assist to toilet every two hours. The care sheet was not consistent with the care plan.<br><br>R13 was continuously observed on 6/4/14, from 7:06 a.m. to 9:55 a.m. (2 hours, 49 minutes) when surveyor informed registered nurse (RN)-A of long sitting time. RN-A and nursing assistant (NA)-B brought R13 into the bathroom near the nurse's station. R13's buttocks area was red but blanched slightly.<br><br>On 6/4/14, at 1:20 p.m., NA-C, stated she had not provided cares for R13 since getting her up in the morning. | F 309 | | |

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| F 309 | Continued From page 17<br><br>On 6/4/14, at 1:25 p.m. NA-B, stated she had not toileted R13 since this morning at 9:55 a.m.<br><br>On 6/4/14, at 1:43 p.m. RN-A said the repositioning time for R13 should be every two hours and verified the care sheet was inaccurate.<br><br>On 6/4/14, at 1:50 p.m. RN-B and NA-A took R13 to the bathroom near the nurses station. R13's buttocks and coccyx were red, but blanched with touch. RN-B stated R13's repositioning should be every two hours.<br><br>During an interview on 6/5/14, at 12:30 p.m. the director of nursing (DON) stated tissue tolerance tests are performed on each resident upon admission and with changes and the determination of the resident's needs and changes in R13's care should have been communicated by notifying staff in report, putting it in the care planning change book, emailing the nursing assistants and nurses with the change, staff was directed to check emails for changes daily, and updating the care plan and care sheets, which staff carry each shift they work. The DON verified the care plan directed staff to reposition R13 every two hours and the care sheets indicated the resident was independent with repositioning. The DON verified she expected the staff to reposition residents according to the care plan.<br><br>The facility policy and procedure for care plans dated 3/14, directed care plans to be kept and maintained in the electronic health record for each resident, staff to follow the care plans, staff to e-mail or leave a note for DON or the MDS coordinator if a care plan looks out of date or the | F 309 | | |

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| F 309 | Continued From page 18 | F 309 | | |

information does not match what is currently being done for the resident. The policy and procedure further indicated the care plans were to be developed, updated and followed by the nursing staff and that all staff is knowledgeable of current care plans.

The facility policy and procedure for skin assessments dated 6/2006, indicated the Braden scale was to be done with each resident on admission and a tissue tolerance assessment was to be done on all residents who cannot reposition independently while in bed or when in a chair. The policy and procedure directed testing to be done on admission, annually, or with a significant change and the resident's care plan was to be updated when a change occurred.

F 312 SS=D — 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS — F 312

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review the facility failed to ensure oral hygiene was provided for 1 of 3 residents (R13) observed for activities of daily living (ADLs).

Findings include:

R13's diagnosis summary list provided on 6/4/14 included diabetes, Alzheimer's disease, anemia,

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| | 245352 | A. BUILDING ______ B. WING ______ | 06/05/2014 |

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| F 312 | Continued From page 19 | F 312 | F312: | |

polymyalgia rheumatica, glaucoma, and osteoporosis.

The annual Minimum Data Set (MDS) dated 1/24/14, indicated R13 has a severe cognitive impairment and required extensive assistance of one staff for personal hygiene, and bathing. The MDS indicated R13 had no impairments of range of motion and had a cavity or broken teeth. The dental care area assessment (CAA) dated 1/31/14, indicated R13 required extensive assistance with all activities of daily living (ADLs), answers yes or no questions, and has a few of her natural teeth that have cracked or fallen out.

The care plan dated 7/15/13, indicated R13 had decreased ability to perform self care activities, including brushing teeth. The care plan directed staff to set up supplies for oral cares and provide verbal cues for R13 to complete tasks.

The nursing assistant care sheet dated 6/3/14, indicated R13 had her own teeth and directed staff to provide oral cares after each meal.

The dental consultation dated 12/9/13, indicated R13 had a broken front tooth and twice daily oral hygiene was recommended.

Oral cares were not observed to be performed during continuous observations on 6/4/14, from 7:08 a.m. when R13 was dressed and seated in the wheelchair through 8:35 a.m. R13 completed breakfast and was brought to the day room at 9:08 a.m. When R13 was brought to the bathroom at 9:55 a.m. by registered nurse (RN)-A and nursing assistant (NA)-B oral hygiene was not observed to be provided.

F312:

It is the policy of Cook Hospital and Nursing home that oral care/hygiene is provided per the Individualized Plan of Care. (see attachment H). Care plans will be followed as written. On 7/9/14. all staff will attend a mandatory training regarding Plan of Care which will include Oral Care/Hygiene expectations. Oral Care/Hygiene policy will be included in new hire education from this point forward.

7/20/14

R13's Plan of care was reviewed and oral care will be provided twice daily.

QAPI will be put in place by DON by 7/15/14 to monitor effectiveness of retraining of job duties and compliance with oral hygiene as specified in the Plan of Care. Ongoing audits and monitoring with process improvement will occur throughout QAPI by DON and MDS Coordinator.

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

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| F 312 | Continued From page 20 | F 312 | | |

NA-C was interviewed on 6/4/14, at 11:30 a.m., and stated she provided cares for R13 in the morning, which included in sequence: dressed, socks were put on, changed brief, peri care, washed face, under arms, and under breasts with a warm wash cloth, put her in the wheelchair, gave her water, and brought her out to the day room. This was repeated back to NA-C and she confirmed that this was the care provided to R13.

On 6/4/14, following lunch at 12:45 p.m. R13 was brought to the dayroom. At 1:20 p.m., NA-C stated that she only had R13 for morning cares and had not performed cares since then. On 6/4/14, at 1:25 p.m. NA-B stated she had not taken R13 to the bathroom or performed cares since 9:55 a.m.

On 6/5/14, at 10:42 a.m., NA-B, stated she provides oral hygiene during morning cares or evening cares if she works evening shift and often used a toothette, as R13 tends to be more receptive to that. NA-B carried the care sheet and the toileting sheet with her in her pocket.

On 6/5/14, at 9:20 a.m. registered nurse (RN)-B was informed that oral hygiene had not been performed on 6/4/14 after breakfast or lunch as directed on the care sheets. RN-B confirmed R13's teeth should have been brushed.

On 6/5/14, at 12:30 p.m. the director of nursing (DON)-B verified that staff should have followed the care plan for oral hygiene.

The policy and procedure for care plans dated 3/14, directed all nursing staff to follow the care plan and to read and follow care plans as outlined.

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|---|---|
| COOK COMMUNITY HOSPITAL C&NC | 10 SOUTHEAST FIFTH STREET COOK, MN 55723 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 465 SS=E | 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based of observation, interview and document review, the facility failed to maintain walls, doors, and/or ceilings; and clean bathroom ceiling vents for 16 of 28 residents (R6, R34, R29, R25, R28, R20, R7, R19, R4, R31, R13, R17, R22, R107, R1, R108) in the facility.<br><br>Findings include:<br><br>On 6/5/14, at 12:37 p.m., an environmental tour was completed with the Environmental Services Director (ESD). The following concerns were observed:<br><br>R6's room had an area (approximately 4 inches x 6 inches) above the headboard which was peeling and gouged. The bathroom ceiling vent had a thick layer of dust. R6 shared the bathroom with R4 and R28. The ESD verified the areas needed repair.<br><br>R34's room floor was dingy and had a light brown stain on the ceiling. The bathroom ceiling vent had a thick layer of dust. The ESD verified the areas needed repair. R34 shared a bathroom with R31 and 107.<br><br>R29's bathroom ceiling vent had a thick layer of dust. The ESD verified the area needed cleaning. | F 465 | F465:<br><br>A policy was developed titled, "Environmental Conditions" **(see attached)** dated 6/27/14 states that the facility must provide a safe, functional, and comfortable environment for resident, staff and the public. Maintenance will perform a weekly environmental inspection of all doors, door frames, windows, floors, walls, ceilings and light fixtures. Identification of damage and repair will be noted on the weekly room inspection checklist for maintenance.<br><br>Per Environmental Services Director upon notification from state surveyors on 6/5/14 housekeeping immediately cleaned and dusted all vents in resident rooms, bathrooms and public bathrooms. Based on company policy this will continue on a weekly basis as noted below.<br><br>Cleaning of Vents was placed on the Housekeepers Extra Duty checklist **(attachment E)** | 7-20-14 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245392 | A. BUILDING ______<br>B. WING ______ | 06/05/2014 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 465 | Continued From page 22<br><br>R25's bathroom ceiling vent had a thick layer of dust. The ESD verified the area needed cleaning.<br><br>R28's bedroom wall had scraped paint along side, and behind the bed. The bathroom ceiling vent had a thick layer of dust. The ESD verified the area needed cleaning. R28 shared a bathroom with R6 and R4.<br><br>R20's wall next to the bed was missing paint in an approximately a 4 inch x 4 inch area with several scrapes at bed level.<br><br>R7's non-skid strips on the floor of bathroom were coming up at edges. A long scratch on the wooden closet door was noted. The ESD verified the areas needed repair.<br><br>R19's bathroom ceiling vent had a thick layer of dust. The ESD verified the area needed cleaning.<br><br>R4's wall, above the headboard, was chipped and gouged. The bedside stand trim along the bottom drawer was falling off. The closet door was scraped. The ESD verified the areas needed repair.<br><br>R31's ceiling tile was stained a light brown. The bathroom ceiling vent had a thick layer of dust. The ESD verified the areas needed cleaning. R31 shared a bathroom with R34 and R107.<br><br>R13 and 17's room wall near the door frame had peeling wall paper. The closet door was scraped. The bathroom, had paint chips on the floor, the counter in front of the sink was dirty and the ceiling vent had a thick layer of dust. The ESD verified the areas needed repair and cleaning. | F 465 | QAPI will be developed by Environmental Services Director by 7/15/14 to audit and monitor environmental conditions. The length of observation/audit time to be determined by QAPI findings.<br><br>Environmental Services Director will provide mandatory education regarding Environmental Conditions policy (**attachment D**) and Housekeepers Extra Duty checklist (**Attachment E**) will be completed for all housekeepers and Maintenance employees by July 4th, 2014.<br><br>Maintenance repairs are currently underway with a target completion date of: July 30th, 2014 based on ordering of replacement items. Work orders include patching, painting of walls, non-skid strips, scratches on doors, repair or replacement of bedside stands, replacement of stained ceiling tiles, wall paper boarder removal from resident room noted as R13 and R17. Replacement of door frame guards for all damaged current door guards. Kick plate replacement on all resident doors leading into their rm. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245292 | A. BUILDING ______ B. WING ______ | 06/05/2014 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 465 | Continued From page 23 | F 465 | F465 (Cont.) | |
| | R22's non-skid strips on the floor of bathroom were coming up at edges. A long scratch on the wooden closet door was noted. | | Environmental Services Director will include a mandatory education for all housekeepers regarding environmental cleaning will be provided. Education is titled, "Top to Bottom" and created in 2014 by the CDC. Date of training: 7/11/14. | |
| | R1's ceiling tile had a light brown stain. The wall vent in the shared bathroom was covered with thick gray dust. R1 shared a bathroom with R108. The ESD verified the areas needed repair and cleaning. | | | |
| | The ESD, interviewed on 6/5/14, at approximately 12:45 p.m., stated the room walls were not part of a preventative maintenance (PM) program. He said the rooms were painted and touched up as the rooms became vacant. He added there were numerous items on the weekly PM list but painting was not part of it. He stated the bathroom vents were to be cleaned twice weekly and acknowledged the vents in the facility had not been cleaned for weeks. | | | |

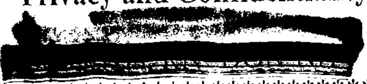
Attachment A

# POLICY AND PROCEDURE MANUAL
# COOK HOSPITAL AND NURSING HOME
# COOK, MN 55723

EFFECTIVE DATE: 06/27/14 REVISION:

****************************************************************************************

SUBJECT: Privacy and Confidentiality

AUTHOR: 

****************************************************************************************

POLICY: The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal cares, visits, and meetings of family and resident groups.

PROCEDURE:

Right to privacy means that the resident has the right to privacy with whomever the resident wishes to be private and that this privacy should include full visual and to the extent desired, for visits or other activities, auditory privacy.

Facility staff must examine and treat residents in a manner that maintains the privacy of their bodies. If an individual requires assistance, authorized staff should respect the individual's need for privacy. Only authorized staff caring for the resident will be present when treatments are given.

Staff will pull privacy curtains, close doors, or otherwise remove residents from public view and provide clothing or draping to prevent unnecessary exposure of body parts during the provision of personal care and services.

Treatment privacy- staff will insure that residents and patients shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination and treatment are confidential and will be conducted as such. When administering treatment such as: blood glucose monitoring, insulin administration staff will ask the resident if they would like to go to a private area. If the resident wants the treatment administered in a common area, the expectation is that staff also asks those residents around the individual receiving the treatment if it is okay to administer or perform the treatment in their presence.

Personal Privacy- Patients and residents shall have the right to every consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Facility staff shall respect the privacy of a resident's room by knocking on door prior to entering room, except in an emergency or where clearly inadvisable.

Administrative Approval: ______________________________ Date: ____________________

Attachment B

POLICY AND PROCEDURE MANUAL
COOK HOSPITAL AND NURSING HOME
COOK, MN 55723

**EFFECTIVE DATE:** March 1994

**REVISION DATE:** November 1995, January 1996
October 1996, August 1997, August 1998, January 2003
July 2003, May 2005, June 2014

****************************************************************************************

**SUBJECT: RESTRAINTS-Assessments/Reductions** **AUTHOR:** [redacted]

****************************************************************************************

**POLICY:**

1. The resident has the right to be free from any physical restraint imposed for purposes of discipline, convenience and not required to treat resident's medical symptoms.

2. If a resident becomes disturbed or difficult behavior creates a management problem, due to the presence of a specific medical symptom, the nurse may take temporary emergency measures using restraints, to protect the resident or others, and the physician shall be called immediately.

3. The least restrictive device will be utilized.

4. Resident will have a Pre- Restraining Assessment Completed as well as an ongoing review for the elimination or reduction of a physical restraint.

**PURPOSE:**

To protect residents from injury to themselves, due to a specific medical symptom, and may be utilized as a measure to attain or maintain the highest level of function with the least restrictive device.

**DEFINITIONS:**

1. Physical Restraints: Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body, that the individual resident can not remove easily, which restricts freedom of movements or normal access to one's body (i.e. wheelchair belt, full side-rails).
2. Physical restraints include but are not limited to: leg restraints, arm restraints, hand mitts, soft ties or vests, lap cushions and lap trays the resident cannot remove easily.
3. Physical restraints also include practices which meet the definition of a restraint such as tucking in a sheet so tightly that a resident confined to bed cannot move; bed rails; chairs that prevent rising or placing a resident in a wheelchair so close to a wall that the wall prevents the resident from rising.
4. Bed rails are considered a restraint if they restrict freedom of movement. If the bed rail is used solely to assist the resident in turning or to help the resident get out of bed, then the bed rail is not used as a restraint.
5. Medical symptoms that warrant the use of restraints will be documented in the resident's medical record, ongoing assessments related to restraint elimination review, and in the plan of care. Examples of "Medical symptoms" as described by the MDH in 144.651(e): 1) a concern for the physical safety of the resident or 2) physical or psychological needs expressed by a resident i.e. a resident's fear of falling.

**PROCEDURE:**

**PHYSICAL RESTRAINTS:**

1. **The "least restrictive" restraint** may be applied after the following is completed:
   a. Physician written order- Must include determinations regarding medical symptoms and specifies the circumstances under which the restraint is to be used, the length of time it will be used and the type of restraint.
   b. **Pre- Restraining Assessment form** (see attached) must be completed by a Licensed Nurse.
   c. **Informed Consent for use of Restraints form** (see attached) is reviewed in detail with the Resident/Patient insuring benefits and risks are thoroughly explained and that resident and/or family representative is in agreement. *The facility may NOT use a restraint solely based on a legal surrogate or representative's request.
   d. Restraints should be released every 2 hours to provide the opportunity for motion, exercise and elimination, for not less than 10 minutes (walk, stand, reposition in wheelchair, checked for incontinence, etc.) Shiftly documentation of restraints and releases are to be charted by nursing staff.

2. **Patient Care Plan** will include at a minimum:
   a. Restraint/Device being utilized and rationale.
   b. Alternatives and reduction plan
   c. Method of ongoing evaluation and review. This is accomplished through the monthly Restraint/Restorative Committee Meeting.
   d. Measures to take to avoid a physical, mental or psychosocial decline such as: restorative nursing programs, activity program development specific for resident.
   e. Consent has been received with Risks and Benefits reviewed with resident/family.
   f. Physician order includes medical symptoms and that he will review restraints at the minimum of quarterly for each individual resident.

3. Documentation of restraints/devices will be within the medical record.

4. A systematic and gradual process utilizing the **Restraint/Restorative Committee** will monitor, evaluate and attempt to reduce and or eliminate restraints on a monthly basis and as needed. Documentation of will be indicated on the **Physical Restraint Elimination Review form** (see attached).

5. Restraints will be reviewed at all quarterly Care Conferences as a TEAM.

6. The MDS Coordinator and the Director of Nursing will maintain a list of residents with devices/restraint.

7. A list of restraints/devices will be posted at each nurse's station by the MDS Coordinator and updated weekly and as needed when changes are made.

## REDUCTION

The Physical Restraint Elimination Review form will be completed monthly and PRN by the Restraint/Restorative Committee.

In addition the committee will perform the following *as needed*:

- All restraint orders will be reviewed. Orders not being used will be eliminated.
- Documentation will be reviewed in regards to Care Plan, MD documentation to determine if updates need to take place, who initiated usage, etc.
- Reduction plans/strategies will be discussed as a team to determine ability to reduce restraints on individual residents.

Resident and families will be educated about the trial for reduction as well as the strategies and plan in place for a goal of elimination of restraint.

Alternatives will be trialed as identified by the Restraint/Restorative Committee in conjunction with the physician's recommendations as appropriate.

**Attachments:** Pre-Restraining Assessment
Physical Restraint Elimination Review
Informed Consent for Use of Restraints

**ADMINISTRATIVE APPROVAL:** ______________________ **DATE:** ____________

**Cook Nursing Home**
INFORMED CONSENT FOR USE OF RESTRAINTS

## DEFINITION OF RESTRAINT

Physical Restraint: Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.

## BENEFITS

Based on the resident's individual need(s), restraints may be beneficial for the following:

- Prevention of injury from falls
- Prevention of injury to self or other
- A provision of necessary treatment
- Other:____________________________________

## POTENTIAL NEGATIVE OUTCOMES

Potential negative outcomes of restraint use include, but are not limited to:

- Declines in the resident's physical functioning and muscle condition
- Contractures
- Increased incidence of infections and development of pressure ulcers
- Delirium
- Agitation
- Incontinence

Moreover, restraint use may constitute an accident hazard. Restraints have been found in some cases to increase the incidence of falls or head trauma due to falls and other accidents (e.g., strangulations, entrapment). Finally, residents who are restrained may face a loss of autonomy, dignity, and self-respect, and may show symptoms of withdrawal, depression, or reduced social contact.

## NURSING HOME POLICY

It is the policy of this facility to use restraint(s) only after assessment and care planning deem it appropriate to treat the resident's medical symptoms and assist the resident in attaining or maintaining his or her highest practicable physical and psychosocial well-being, and other methods or interventions are inadequate. In all instances, the least restrictive device, which is effective, will be used.

The facility will monitor the resident's status and adjust care, as necessary. The facility will have a systematic and gradual process to reduce the use of restraint(s) to ensure the resident's safety while treating the resident's medical symptoms.

***I have been informed that an evaluation has been done by the appropriate healthcare professional(s) to determine the appropriateness of the following:***

- ☐ ***Use of restraint(s)***
- ☐ ***Participation in the restraint reduction program***

**************************************************************************************************************************

Resident Name:____________________________Room #:____________

ID#:________________ Physician:__________________________

Cook Nursing Home

# PRE-RESTRAINING ASSESSMENT

This form has been developed to adequately assess all aspects of the resident's well-being (physical, mental, emotional, environmental and social considerations) prior to the use of either medication interventions or physical restraining devices in order to identify the least restrictive intervention. It is to be completed by a nurse or licensed physical/occupational therapist.

## PHYSICAL AND MENTAL CONSIDERATIONS

| MENTAL STATUS | YES | NO |
|---|---|---|
| Alert | | |
| Short attention span | | |
| Disoriented | | |

| BALANCE (When Sitting) | YES | NO |
|---|---|---|
| Falls forward | | |
| Falls/leans sideways ☐ Right ☐ Left ☐ Both | | |
| Slides down | | |
| Slumps | | |

| RECOVERY OF BALANCE (While Sitting) | YES | NO |
|---|---|---|
| Forward | | |
| Backward | | |
| Sideways | | |

| AMBULATION | YES | NO |
|---|---|---|
| Unsteady on feet | | |
| Loses balance | | |
| History of falls | | |
| Foot problems | | |
| Takes short steps | | |
| Steps on own feet | | |
| Leans to side | | |
| Leans backward | | |
| Leans forward | | |
| W/C mobility | | |
| Other:______ | | |

| VISION/MUSCLE CONTROL | GOOD | | FAIR | | POOR | | NONE | |
|---|---|---|---|---|---|---|---|---|
| | R- | L- | R- | L- | R- | L- | R- | L- |
| Vision (R-right; L-left) | | | | | | | | |
| Muscle control | | | | | | | | |

PARALYSIS/PARESIS - (✓ if present)

Arm ☐ Right ☐ Left   Hand ☐ Right ☐ Left   Leg ☐ Right ☐ Left   Foot ☐ Right ☐ Left

| POTENTIAL MEDICAL FACTORS AFFECTING BEHAVIOR | YES | NO |
|---|---|---|
| Medication change or addition in past month? | | |
| Possible infection? | | |
| Dehydration or electrolyte imbalance? | | |
| Acute hypoxia? | | |
| Toxic drug levels? | | |
| Change in baseline vitals? | | |
| Recent trauma? | | |
| Other:______ | | |

| HAS RESIDENT EXPERIENCED A RECENT: | YES | NO |
|---|---|---|
| Change of roommate? | | |
| Room change? | | |
| Transfer? | | |
| Surgery? | | |
| Care giver or staff change? | | |
| Other:______ | | |

## EMOTIONAL, ENVIRONMENTAL AND SOCIAL CONSIDERATIONS

| POTENTIAL CONTRIBUTING BEHAVIORAL FACTOR | YES | NO |
|---|---|---|
| Glasses: ill-fitting, dirty or missing | | |
| Dentures: improper fitting or uncomfortable | | |
| Ears impacted with cerumen | | |
| Hearing aid malfunctioning | | |
| Poor lighting or flickering lights | | |
| Needs to go to the bathroom | | |
| Has wet or soiled clothing, bed linen | | |
| Is hungry or thirsty | | |
| Needs position changed; is cold/warm | | |
| Environmental barriers | | |
| Misinterprets words, sounds | | |
| Feels threatened by other residents | | |
| Is searching for a missing item | | |

| POTENTIAL CONTRIBUTING BEHAVIORAL FACTOR | YES | NO |
|---|---|---|
| Does not understand what is being said | | |
| Can not comprehend surroundings | | |
| Affected by environmental noise level (i.e., radio, television, staff) | | |
| Recent loss due to own illness | | |
| Recent death/loss of a loved one | | |
| Recent change in financial status | | |
| Loss of self-control | | |
| Experiencing feelings of anger, fear, abandonment | | |
| Experiencing feelings of loneliness or isolation | | |
| Other:______ | | |

## REFERRALS/RECOMMENDATIONS

**INTERDISCIPLINARY TEAM EVALUATION** Date ___/___/___ Recommendations: ______

Plan of Care Updates ☐ No ☐ Yes; If yes, Date ___/___/___

Alternatives to restraints (include length of time to be tried) ______

**NEXT EVALUATION** ___/___/___ Signature/Title ______ Date ___/___/___

**REFERRED TO PSYCHOLOGIST OR PSYCHIATRIST** ☐ No ☐ Yes; Date ___/___/___ Recommendations: ______

**REFERRED TO PHYSICAL OR OCCUPATIONAL THERAPIST** ☐ No ☐ Yes; Date ___/___/___ Recommendations: ______

| NAME–Last | First | Middle | Attending Physician | Record No. | Room/Bed |
|---|---|---|---|---|---|
| | | | | | |

Signature:______ Date:______

Attachment C

# POLICY AND PROCEDURE MANUAL
# COOK HOSPITAL AND NURSING HOME
# COOK, MN 55723

---

**EFFECTIVE DATE:** October 1990

**REVISION:** November 1995, May 2000 December 2004, November 2011, March 2014, 6/14

*****************************************************************************************

**SUBJECT: CARE PLAN COMPREHENSIVE -NURSING**
**Nursing Home Resident/Swing Bed Patient**

**AUTHOR:** [redacted]

*****************************************************************************************

**POLICY: A Comprehensive Care Plan will be developed for each resident that includes measurable objectives and timetable to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The Care Plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. Respecting and noting that a resident has the right to refuse service.**

**PROCEDURE:**

1. **Care Plans are kept and maintained in the EHR for each resident.**
2. **The care plan needs to be followed at all times.**
3. **Current Care Plans are accessible to nursing staff at all times through the EHR.**
4. **The nursing assistants are educated to email or notify the MDS Coordinator, Charge Nurse or DON immediately if any care plan discrepancies exist.**
5. **All staff must follow the POC.**
6. **State and Federal guidelines mandate that care plans be developed and followed and that all staff is knowledgeable regarding the POC.**
7. **Care Plans are to be kept consistent and up to date to reflect resident's current needs.**

**<u>Preparation:</u>**

1. The nurse and MDS Coordinator collects data about the resident from:
   - Admitting information from physician, resident, family transferring facility and social history, Nursing history, MDS and interview with resident/swing bed patient. Communication with physician, family and nursing staff.
   - The resident will participate in the development and ongoing implementation of their Plan of Care.
2. Identifies problems/needs and vulnerabilities.
3. Identifies potential goals within all disciplines which pertain to the individual resident.
4. Identifies nursing rehab/physical therapy areas of concern.
5. The Care Plan must be initiated within 7 days of admission and reviewed Quarterly.
6. The Care Plan will also be revised related to status changes.
7. The physician will review the POC (Plan of Care) at a minimum of quarterly during physician rounds.

**<u>Special Considerations:</u>**

1. The MDS Coordinator will review specific medications that residents are on and include signs/symptoms to monitor for in regards to the specific medication insuring that a problem statement, goal, indications and interventions are clearly stated. i.e. (diuretics, Coumadin/warfarin/lovenox, and insulin).

**Implementation:**

1. The nursing administration and nursing staff is responsible for insuring that the total nursing care plan is implemented after communicating it to staff and resident/swing bed patient.
2. Assure that the resident/swing bed patient assignments sheets accurately reflect the care plan.
3. Personal observation of care given the resident.
4. Discussion of care plan with staff.

***Refer to Comprehensive Assessment Policies for ancillary departments.**

**Administrative Approval:**____________________________________**Date:** ___________________________

Attachment D

# POLICY AND PROCEDURE MANUAL
## COOK HOSPITAL AND NURSING HOME
COOK, MN 55723

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EFFECTIVE DATE: 06/27/14 REVISION:

******************************************************************************************

SUBJECT: Environmental Conditions

AUTHOR: [redacted]

******************************************************************************************

POLICY: The facility must provide a safe, functional, sanitary, and comfortable environment for resident, staff and the public.

PROCEDURE:

1. Maintenance department will perform a weekly environmental inspection of all doors, door frames, windows, floors, floor non-skid strips, walls, ceilings and light fixtures. Identification of damage and repair will be noted on the weekly room inspection checklist for maintenance.
2. Upon discharge of residents in the Nursing Home, the Charge nurse will notify maintenance via work order for inspection and repairs of unit.
3. Wheel Casters are in place on all regular beds to prevent marring of walls. Wheel Casters will be replaced as necessary.
4. HI/LO beds have braces between wheels and walls to prevent the bed from damaging the wall.
5. Housekeeping will be assigned weekly to dust vents and all high area surfaces.

Administrative Approval: ______________________________ Date: ____________________

Attachment E

**Cook Hospital & Nursing Home**
**HIGH AREA DUSTING CHECKLIST**
**WEEKLY**

Place a check in the box after cleaning is complete.

- ☐ Ceiling, wall and ceiling vents
- ☐ Frame work around all doors and windows (bathroom, closet, etc.)
- ☐ Blinds
- ☐ Window sill
- ☐ Shelves
- ☐ Light fixtures
- ☐ Wall clocks
- ☐ Television sets
- ☐ Bulletin boards
- ☐ Bedside stands and dressers
- ☐ Personal picture frames and other nick-knacks

Date Completed:__________________ Employee:______________________________

**When complete, place form in Maintenance Director's mailbox.**

F5392022



| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245392 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 06/03/2014 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS | K 000 | | |

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

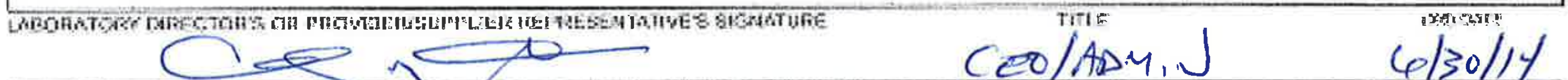
A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on June 3, 2014. At the time of this survey Cook Hospital C & NC was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES ( K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
444 Cedar St., Suite 145
St. Paul, MN 55101- 5145, or

POC ok
PS 7-8-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO/ADM. (X6) DATE: 6/30/14



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.

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 |
| --- | --- | --- | --- |
| | 245392 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 06/03/2014 |

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

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

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| K 000 | Continued From page 2<br><br>The standard is NOT met as evidenced by: | K 000 | | |
| K 050 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2<br><br>This STANDARD is not met as evidenced by:<br>Based on review of available documentation and interview, it was determined that fire drills were not conducted at as required by LSC(00) Section 19.7.1.2. This deficient practice could affect all occupants in in the event of a fire emergency.<br><br>Findings include:<br><br>On 6-3-14 at the conclusion of the inspection, at approximately 10:30AM, based on a review of available fire drill documentation it was determined that fire drills were not documented in the past 12 months) as required. The information on the form currently used by the facility does not provide all of the documentation to make a determination of the quality of the drill. A new form was provided at the time of inspection.<br><br>This deficient practice was confirmed by the | K 050 | K050:<br><br>It is the policy of Cook Hospital and Nursing Home to hold fire drills in accordance with state and federal standards while following the Life Safety Code. Refer to Fire and Evacuation Plan (**attachment F).**<br><br>Environmental Services Director has performed Fire Drills x2 on days, x1 afternoons, x 1 midnights throughout the month of June, 2014. Drills will continue on all three shifts as per regulation. This will be performed and monitored by the Environmental Services Director through QAPI with specific interventions and auditing schedules determined throughout project.<br><br>Environmental Services Director has implemented as of June 11, 2014 the Fire Drill Report Form (**Attachment G**) which meets Life Safety Code standards for proper documentation. | |

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| K 050 | Continued From page 3<br>facility Director of Maintenance (MP) at the time of exit | K 050 | | |

*Protecting, Maintaining and Improving the Health of Minnesotans*

Certified Mail # 7013 2250 0001 6357 1515

June 18, 2014

Mr. Allen Vogt, Administrator
Cook Community Hospital C&NC
10 Southeast Fifth Street
Cook, Minnesota 55723

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5392024

Dear Mr. Vogt:

The above facility was surveyed on June 3, 2014 through June 5, 2014 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, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

When all orders are corrected, the order form should be signed and returned to this office at:

Patricia Halverson,Unit Supervisor
Minnesota Department of Health
11 East Superior Street, Suite #290
Duluth, Minnesota 55802.

Telephone: (218) 302-6151
Fax: (218) 723-2359

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 Patricia Halverson at the number above.

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,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring

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

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5392s14lic.rtf