DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: GDZF

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY A	AGENCY		Facility ID: 00586	
1. MEDICARE/MEDICAID PROVIDE (L1) 245392 2.STATE VENDOR OR MEDICAID N (L2) 752547802		3. NAME AND AL (L3) COOK COM (L4) 10 SOUTHE (L5) COOK, MN	MUNITY HO CAST FIFTH S	OSPITAL C		55723	4. TYPE OF 1. Initial 3. Terminat 5. Validatio	2. Recertification ion 4. CHOW n 6. Complaint	
5. EFFECTIVE DATE CHANGE OF (L9)		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site V 8. Full Surv	/isit 9. Other rey After Complaint	
6. DATE OF SURVEY 07/30 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR	E ENDING DATE: (L35)	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	28 (L18) 28 (L17)	Complianc1. A		gram	2. Tech 3. 24 H 4. 7-Da 5. Life	nical Personnel	7. Med	be of Services Limit ical Director ent Room Size	
14. LTC CERTIFIED BED BREAKDO	WN	1			15. FACILITY M	IEETS			_
18 SNF 18/19 SNF 28	19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L1:	5)	
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SUF	RVEY AGENCY	APPROVAL	Date:	
Patricia Halverson,	Unit Superv	visor 0	8/14/2014	(L19)	Enfo	orcement	Specialist	09/11/2014	.20)
PAR	T II - TO BE (COMPLETED B	Y HCFA RE	GIONAL	OFFICE OR	SINGLE ST	ATE AGENO	•	
19. DETERMINATION OF ELIGIBIL _X	articipate		IPLIANCE WITI HTS ACT:	H CIVIL	2. C			FFA-2572) re Stmt (HCFA-1513)	
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINA	TION ACTION:		(L30)	
OF PARTICIPATION 12/01/1986	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 01-Merger, Clos		05-	VOLUNTARY Fail to Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfactio			Fail to Meet Agreement	
25. LTC EXTENSION DATE:		IVE SANCTIONS n of Admissions:	(L44)		03-Risk of Involu 04-Other Reason	•	<u>01</u> 07-	<u>'HER</u> Provider Status Change -Active	
(L27)	B. Rescind S	uspension Date:							
			(L45)						
28. TERMINATION DATE:	29	9. INTERMEDIARY/	CARRIER NO.		30. REMARKS				
		03001			Poste	d 09/24/2014	4 Co.		
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	I OF APPROVAI	DATE					
	(L32)	08/04/2014		(L33)	DETERMIN.	ATION APPR	ROVAL		_



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 Moath Enforcement Specialis

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 245392	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 7/25/2014
Name	of Facility		Street Address, City, State, Zip Code	
CC	OOK COMMUNITY HOSPITAL C&NC		10 SOUTHEAST FIFTH STREET COOK, MN 55723	

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

(Y4) Item	(Y5) Date	(Y4)	Item		(Y5)	Date	(Y4)	Item	(Y5)	Date
		Correction					Correction					Correction
		Completed					Completed					Completed
ID Prefix	F0164	07/20/2014		ID Prefix	F0221		07/20/2014		ID Prefix	F0279		07/20/2014
	483.10(e), 483.75(l)(4)				483.13(a)				-	483.20(d), 483.2	0(k)(1)	
LSC				LSC					LSC			
		Correction					Correction					Correction
ID Prefix	F0280	Completed 07/20/2014		ID Prefix	F0282		Completed 07/20/2014		ID Prefix	F0309		Completed 07/20/2014
	483.20(d)(3), 483.10(k)(483.20(k)(3)(ii)		-			483.25		
LSC				LSC	403.20(K)(3)(II)				LSC			_
			-									_
		Correction					Correction					Correction
		Completed					Completed					Completed
ID Prefix	F0312	07/20/2014		ID Prefix	F0465		07/20/2014		ID Prefix			
Reg. #	483.25(a)(3)				483.70(h)		_		Reg. #			_
LSC				LSC			-		LSC			_
		Correction					Correction					Correction
ID Prefix		Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. # LSC				Reg. # LSC			=		Reg. #			
	-						-					
		Correction					Correction					Correction
		Completed					Completed					Completed
ID Prefix				ID Prefix			· -		ID Prefix			
Reg. #				Reg. #					Reg. #			
LSC				LSC					LSC			_
Reviewed By	· —		Da	te:	Signature o	of Surve	-				Date:	
State Agenc	y PHI	L/mm	08	/11/201	.4		128	335			07/	25/2014
Reviewed By	y — Review	ed By	Da	te:	Signature o	of Surve	yor:				Date:	
CMS RO												
Followup to	Survey Completed on:				Check	for any	Uncorrected	Deficie	ncies. Was	a Summary of		
	6/5/2014				Unc	orrecte	d Deficiencie	s (CMS	-2567) Sent	to the Facility?	YES	NO

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 245392	(Y2) Multiple Constru A. Building B. Wing	N BUILDING 01	(Y3) Date of Revisit 7/18/2014
Name of Facility		Street Address, City, State, Zip Code	
COOK COMMUNITY HOSPITAL C&NC		10 SOUTHEAST FIFTH STREET COOK, MN 55723	

This report is completed by a 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	()	(4) Item		(Y5) I	Date
		(Correction				Correction					Correction
			Completed				Completed					Completed
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LSC	K0050				LSC				LSC			_
		(Correction				Correction					Correction
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Reviewed By	Review	ed B	у	Da	te:	Signature of Surve	yor:				Date:	
State Agency	, PS/:	mm	<u>1</u>	08	3/11/2014	1 -	3005				07/1	8/2014
Reviewed By	Review	ed B	у	Da	te:	Signature of Surve	yor:			<u> </u>	Date:	<u> </u>
CMS RO												
Followup to Survey Completed on:					Check for any	Uncorrected	Def	ficiencies. Was	a Summary of	1		
	6/3/2014								MS-2567) Sent	-	YES	NO
				_								

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: GDZF

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

	PART I - TO BE COMI	THE STAT	E SURVEY AGI	ENCY	Facility ID: 00586			
MEDICARE/MEDICAID PROVIDER NO. (L1) 245392 2.STATE VENDOR OR MEDICAID NO. (L2) 752547802	3. NAME AND ADD (L3) COOK COM (L4) 10 SOUTHEA (L5) COOK, MN	MUNITY HOSP	PITAL C&N		55723	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUP 01 Hospital	05 HHA	Y 09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other omplaint	
6. DATE OF SURVEY 06/05/2014 (L 8. ACCREDITATION STATUS: (L) 0 Unaccredited	34) 02 SNF/NF/Dual 10) 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING	DATE: (L35)	
	X B. Not in Comp	ce With quirements Based On: cceptable POC	n	2. Techn 3. 24 Ho 4. 7-Day 5. Life S	nical Personnel our RN y RN (Rural SNF)	Following Requirements: 6. Scope of Servi 7. Medical Direc 8. Patient Room 9. Beds/Room (L12)	tor	
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19	SNF ICF	IID		15. FACILITY ME		(L15)		
28 (L37) (L38) (L	L39) (L42)	(L43)						
16. STATE SURVEY AGENCY REMARKS (IF APPLIC	ABLE SHOW LTC CANCELL	ATION DATE):						
17. SURVEYOR SIGNATURE		Man	EY AGENCY APP	ath	Date:			
Teresa Ament, HFE NEII		07/16/2014	(L19)		ement Spe		08/04/2014 (L20)	
PART II	- TO BE COMPLETED	D BY HCFA R	EGIONAL	OFFICE OR S	INGLE STATI	E AGENCY		
DETERMINATION OF ELIGIBILITY		PLIANCE WITH C	CIVIL	2. O		al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	A-1513)	
(L21)			ı				
	REEMENT 2- NNING DATE	4. LTC AGREEMI ENDING DAT		26. TERMINATI VOLUNTARY 01-Merger, Closure	00	INVOLUNT	(L30) <u>FARY</u> leet Health/Safety	
(L24) (L41)		(L25)		02-Dissatisfaction		t 06-Fail to M	leet Agreement	
A. Susp	NATIVE SANCTIONS pension of Admissions: cind Suspension Date:	(L44)		03-Risk of Involunt 04-Other Reason fo	•	OTHER 07-Provider 00-Active	Status Change	
		(L45)						
28. TERMINATION DATE:	29. INTERMEDIARY/CA	ARRIER NO.		30. REMARKS				
(L28)	03001		(L31)	Posted	08/04/201	4 Co.		
31. RO RECEIPT OF CMS-1539	32. DETERMINATION O	OF APPROVAL DA	TE					
(L32)			(L33)	DETERMINA	TION APPROV	VAL		



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

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

PRINT FO: INSTACED14 FORM APPRIVED OMB MO.0938-0391

	OF DEFICIENCES CORRECTION	(хт) радминивийныйнайнайн жентентенийныйныйнайн жентентенийныйныйныйныйныйныйныйныйныйныйныйныйный	ies; woltpl a. Bureing	ECCHISTRACTION RECEIVED	COMPLETED (XIS DATE SURVEY	
		245152	e. Wing	U	i Oso	15/2014
	SOVIDES OF SLEWLING		ij	Treet Address, city, State, 20° core Discuthea y: Pyth Street Down, MN 35723		
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F 000	WILL SERVE AS 'COMPLIANCE UI ACCEPTANCE. Y BOTTOM OF THE	LAN OF CORRECTION (POC) YOUR ALLEGATION OF YON THE DEPARTMENT'S OUR SIGNATURE AT THE E FIRST PAGE OF THE I WILL BE USED AS	F 000	corrections stated herein have be completed or will be completed of assigned dates: Julie Gerzin, RN/DON-NH	on	
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL C REGULATIONS H	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE OVALIDATE THAT OMPLIANCE WITH THE HAS BEEN ATTAINED IN MITH YOUR VERIFICATION.	The state of the s	Per phone conversation al Vogt, ad mines track 7/2/14- all convert dates should be 7/20	119	
F 164 55-0	Census 28 4(3,10(e), 483.75 PRIVACY/CONFI	(I)(4) PERSONAL DENTIALITY OF RECORDS	F 184		PLH)	7/20/14
ייניים איניים איניי איניים איניים	The resident has confidentiality of I records.	the right to personal privacy and as or her personal and clinical				
And the second s	medical treatment communications, meetings of tamb	includes accommodations, i, written and telephone personal care, visits, and y and resident groups, but this like isolity to provide a private sident.	7-7-1 GPN	(4) (PH		
	section, the resid	ed in paragraph (e)(3) of this lant may approve or refuse the rai and clinical records to any riha facility.	Complete to the second of the control of the contro			and the second second second second
1.5 20 17 17 17 18 18 18 18 18 18 18 18 18 18 18 18 18	and clinical reco	tht to refuse release of personal de does not apply when the w <u>nerosuppose resenesentanves si</u>	SHAT WEB	TILLE		nong Clesses

Any deficiency statement ending will an architek (*) denotes a descioncy which the institution may be excused from correcting providing to a determined first, other subgraving provide deficient provided to the patients. (See anstructions.) Except for making home. The findings stated shows are disclosable th days inflowing the date of survey whether or not a plan of correction is provided. For musing fromes, the above findings and plans of correction are disclosable fid days following the date these documents are made socialish to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT	LOGSRECTION DE DELCIENCES PLOK MEDICAKE	& MEDICAID SERVICES (XI) STRUMBERALEGICE IA DENTIFICATION NUMBER	(XI) MUI A BUILE			CONSTRUCTION	OF DATE	e slevet Pleted
		245392	e.was				06J	05/2014
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<u>arramanan sanda</u>					:	F164: It is the policy of the Cook		
F 164	Continued From pa	ige 1	F	164	Ĭ.	Hospital and Nursing Home to pr	ovide	
	resident is baralen	ngij lo griolher health café d seleces is required for levy				privacy for all residents when		
	Bigingeri, er lenni	I release is required by law.			,	treatment is administered such a	iS	
	The facility must ke	rep confidential all intermation			7	insulin or blood glucose monitori		·
	the form or storage	sident's records, regardless of methods, except when			1	The Nursing Home policy titled	J	: .
	i jelesse is requiled Lealibose inslibili	by transfer to another on, law, third party payment			1	"Privacy and Confidentiality" (see	e	
	contract; or the res		1			attachment A) was updated on		
	:		1		1	6/27/14 and reads as follows:		•
	by: Based on observations administration for administration for administration was considered by the facility of the daylactivity room, with several visite the daylactivity wrapped in a whit barely verbally or RN-A powed R201 and applied a drootservation of the daylactivity wrapped in a whit barely verbally or RN-A powed R201 and applied a drootservation.	8 a.m. during the medication pervation registered nurse wed to perform a blood glucose the with R20 in the facility's Several other residents along rewere observed to be seated more. R20 was observed to be blanket and was noted to physically respond to RNA as a fourth finger on the left hand poly R20's blood to a strip in the			emperator com a communicación destablem entre esta de la comprese y experiencial material de estable establem	Treatment Privacy: Staff will insuthat residents and patients shall the right to respectfulness and pas it relates to their medical and personal care program. When administering treatment such as Blood glucose monitoring, insuli administration staff will ask residence would like to go to a private of the resident wants the treatment administered in a common area expectation is that staff also will those residents around the indivinceiving the treatment if it is of	have privacy it is the content of t	
The second and second	blood glucose mo monitarina proces	oilor. After R20's blood glucos: ture was completed, RN-A was n to R20 and injected the insufir	6		teres out of the second	administer or perform the treat their presence.	ment in	

An electronic Diagnosis Summary dated 5/16/14,

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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F 164	Continued From pa Indicated P20's dia metitus type 2.	ge 2 gnoses included diabetes	F	164	F164 (cont.) Ongoing audits/monitoring will be performed throughout the next.		
	approach R30 with monitor. R30 was daylactivity room. I scaled at the table a finger on R30's to	a m. RN-A was observed to a prepared blood gluccae seated at the table in the Vlany other residents were RN-A was observed to poke It hand and applied a Grop of prepared blood gluccae		The second secon	months and intermittently after time by the DON and/or MDS Coordinator to insure complianc treatments and privacy.	such	į.
	monitor. An electronic Diagr	orepares trosti glocuse tosis Summary datad \$730/14, , grosses included diabetes	The second secon		DON will record results of audits through QAPI. RN/LPN staff in the NH will be re		
	On 6/4/14, at 1:40 places the Blood gluc the Blood gluc the Blood gluc the Insulin administration with ask the resident if I glucose monitoring administration with daylactivity room a residents who are placed glucosedures it stated she did ask comfortable with recommon areas, but privacy or ask the privacy or ask the privacy or ask the blood glucose monations areas administration.	o.m. RN-A stated she usually case monitoring precedure and ration in the common areas of ather stated she would usually tis alight to do the blood procedure and insufin a others are present in the other casent, if they are alright with a the common areas. RN-A R20 and R30 if they were calving the procedures in the titler residents if they were ther R20 or R30 receiving the litering and/or the insufin			educated in regards to updated on 6/27/14. Licensed staff not provide will review and sign the new polithe next scheduled shift worked. In addition all future Licensed state be educated upon hire.	resent icy on	
	sealed in the dining was observed to a administer insulin i	a.m. R20 was observed to be g room of the facility. RN-8 aproach R20 and liten n the back of R20's left upper nate along with several other	Section 1		i ·		Si (Sillentine Little Acidente Little Sillentine

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		2452-92	245392 B. WWD					
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	com eating break On 6/6/14, at 9:42 does the insulin so areas of the facility when other reside stated sive normal alright with receivit does not always a they are alright wit place in a public it are squeamish. On 6/5/14, at 10:4 (DON) stated the glucose monitorin administration of when she was in The DON further when asked to gr procedure or adn The DON confirm asked if they war types of procedu providing for that A privacy policy of provided. 11 483.13(a) R3GH D PHYSICAL RES The resident has physical restrain discretions or con-	led to be present in the dining fast. a.m. RN-B sibled she usually siministration in the common y, such as the dining room, nis are present. RN-B further by asks the resident if they are ng the insulin injection, but sk the other residents present in the insulin injection taking ecotion, unless she knows they control the director of nursing topic of performing blooding procedures and the charge of risk management, stated most of the residents of a private location for these told the nurses to just do the ninister the Insulin right here, and the residents should be residents should be residents. If no the FREE FROM	- 4			7-20-14		

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FECHICLES IN AN OF CONNECTION œach corrective action should be CHICHS MEFERENCED TO THE AFFIXFRIDATE DEFICIENCY

iód Alemania MIL

F 221 Communed From page 4

This REQUIREMENT is not met as evidenced

SURRAWS STATEMENT OF DEFICIENCIES

Based on observation, interview and document review, the facility did not ensure 1 of 1 resident (R1) reviewed for restraints was assessed for the sale and continued use of a lap belt restraint. In adollon, the facility did not ensure clinical andications for the use of the restraint.

Findings include:

Rit's diagnoses listed on the History and Physical (HRP) dated 4/25/14 included dementia from Alzhemer's disease, a history of degression, rhoumatoid authrilis and osteoporosis. The quartedy Minimum Dala Set (MDS) daled 4/14/14, imprested R1 had severe cognitive impairment. R1 required the total assistance of two staff to transfer. At required the extensive assistance of two staff with bed mobility and kolleting; 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) list with all transfers and required iotal assistance with locomotion in the "tit" 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 bell at all limes 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 socol down in the wheelchair to scratch her head by rubbing it against the back of the wheelchair. R1 needed a Velcro restraint balt.

F221 "Restraints-F 221

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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qi Pretm Tast PROVOCES PLAN OF CORRECTION SEASH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE OFFICIENCY (ASI C:PIFILINGA DASI

F 221 : Continued From page 5

Approaches included a Velcro belt to help prevent stiding or sceoting 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.

On 6/03/14 during the breakfast meal R1 was observed in the dining room in lift wheelchair. Two white strep crossed in the back of the wheelcheir and attached to the anti-tip bars of the wheelchair, R1 was covered with a blanker and the straps were coming out from around R1. Observation of R1's wheelcheir when when R1 was in bad displayed a Velero strap that went across and connected with Veloro to the strap on the opposite side of the wheelcheir. On \$14/15, during the breakfast and lunch meal staff was observed to open the lap belt while assisting R1 with eating. After both meals R1 relumed to her room was out to bod. R1 was not observed to move herself, other than the same, in the wheelches.

On 6/5/14 at 16:55 a.m. the director of nursing (DON) stated R1 could open the tap belt but did not know if she could open the tap belt overy 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 ewhite 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 tell 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 frow 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."

R1 will be reviewed on 7/1/14 for a potential reduction of restraint (Velcro lap belt) during the Restraint/Restorative Committee meeting.

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.

Future employees will receive restraint education during new hire orientation.(Cont.)

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F 321	Continued From page 6
	and benefits, and restraint for meeting rotes

On 6/6/14, at 12:30 p.m. the occupational therapist (OT) was interviewed. The OT stated R1 has had the till wheelchair for a long time, "At least 5 years". R1 had the tap belt in the wheelchair before getting the lift 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.

SLAMMARY STATEMENT OF DEFACESSIES

TEACH DESIGNATION WITH SE PRECEDED BY FAIT

HEISIN AT DELY CHE LECT HEEMTH YOUR INFORMATE IN

The Resiraint policy revised May 2005, indicated the resident had the right to be free from physical restraint imposed for purposes of disciplina . convenience and not required to treat a residents medical condition. The least restrictive device would be utilized. The purpose of the policy was to copiect 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, allematives and reduction. A systematic and gradual process would initiate reduction of the restraints. The IDT would review the restraints every week. Assessments and what restrains device would be used would be determined by the IDT.

F 279 483.20(d), 483.20(k)(1) DEVELOP SS=D COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the residents comprehensive plan of care.

F221 (cont.)

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.

PRINCIPLE FLAN OF CORRECTION

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F 278	Continued From p		F 27	F279:	,	7-20-14
	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.		It is the policy of the Cook Hospit Nursing Home to develop a Comprehensive Care Plan for eac resident to include measurable objectives and timetables to mee	:h		
	to be furnished to highest practicable	st describe the services that are allain or maintain the resident's a physical, msnlal, and		resident's medical, nursing, ment and psychosocial needs.		:
	psychosocial well-	being as required under services that would otherwise	1	The "Care Plan Comprehensive-		•
	ha remuired under	4463,25 but are not provided		Nursing" policy (See attachment		*
	due to the resident cast of the cast of th	ifs exercise of rights under I the right to refuse breatment		was revised on 6/27/14 to includ		1
	(a)der §453.10(b)	(4).		"special considerations" in which		:
	i i		•	states, "the MDS Coordinator wi review specific medications that		
	•	ENT is not met as evidenced	2 1 1	residents are on and include		:
	by: Resed on observ	ation, interview and document		signs/symptoms to monitor for i	n	
	review, the facility	failed to ensure the care plan	į	regards to the specific medication		-
	was devaloped lo receiving dicretica	ir 1 of 5 residents (R28) a and insulin, and 1 of 5		insuring that a problem stateme		ž ž
	residents (R4) rec	zawing Colembia.		goal, indications and interventio	ns are	:
			al production	clearly stated. i.e. diuretics,		

Findings include:

P28's diagnoses from the summary list and medication is for May/2014, include disheles, edema, hypertension, ascillas, and anoma.

The Minimum Data Set (MDS) dated 5/26/14, indicated R28 was cognitively intact and required extensive assistance of one stall for bed mobility and dressing, extensive assistance of two staff for fransfers and toileting, limited assistance of one staff for wheelchair ocomption and personal hygiene, and was independent with eating. The

Coumadin/warfarin/lovenox, and insulin.

MDS Coordinator was educated on the revised policy above on 6/27/14.

MDS Coordinator is reviewing all care plans to insure that these medications/signs symptoms, etc are

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ang Prefek ID FROMDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (REFERENCE) COMPLETON MATE

F 279 : Continued From page 8

MDS further indicated R28 received insulin and a diureto.

R28's signed physician orders of 4/15/14. directed Spironolastone (diuretis) 25 milligrams (mg) daily and Insulin (for diabetes) for R28. Signed physician orders of 5/19/14, directed Lasix 20 mg daily.

The medication administration record (MAR) dated May 2014, indicated R28 received Insulin as ordered by the physician for diabetes, Spironolactone 25 mg BID and lastx (diuretic) 20 mg daily for hypertansics.

R26'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 lask or Spironolacters

During an interview on (US/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.

The facility was unable to provide a policy and procedure for the development of care plans.

An electronic Summary - Diagnoses form dated 5/23/14, indicated R4's diagnoses included striat fibriliation.

An annual MDS dated 4/6/14, indicated R4's Brief Interview for Menial Status (BIMS) score was 13, depicting R4 as cognitively intact F 279

(F279 Cont.) Completion date assigned is July 13th, 2014.

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.

Newly hired licensed staff will receive education during orientation.

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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A comprehensive care glan must be developed within 7 days after the comprehensive care glan must be developed within 7 days after the postportural processor and participate of the State o		of Deficiencies of Correction	HELLER BERTHIERER CERT		CONTROL NEED TROPE		obeceten Celebrand	
CODX COMMUNITY MOSPITAL CANC PROJECT SUMMARY STATEMENT OF SEPORNOSS SECURITY SEPORNOSS SECURITY OF USE DETERMINED PROJECT ON THE PROJECT ON			245352	ê 4446	restrigites the last training to the state of the state o	06/	D5/2014	
Figure 1 Security States of the persistency with 1 Security States of the persistence of			L C&NC	g tr	SOUTHEAST PIPTH STAGET	mgariam order 50 4 (24) (41)		
R4's Medication Administration Record Physician's Orderaly as disted 5/18/14, indicated Cournadin po (crafty) as directed. Amonthly medication schedule dated 6/14/4, to 7/14/4, indicated R4 had been receiving Cournadin 7.5 mg by mouth daily. Review of R4's Plan of Carc (POC) last reviewed 4/18/14, indicated a tack of a problem, outcome or intervention to address the use of Cournadin. R4 was observed throughout the survey week of 6/2/14, through 6/5/14. On 8/5/14, at 9:48 a.m. registered nurse (RN)-B stated R4 had been receiving Cournadin daily. RN4-5 inther stated any side effects from the Cournadin would be documented in the pregress noise. RN-B continued R4's POC stacked a problem statement, an outcome and any interventions related to R4 receiving the Cournadin. On 6/5/14, at 10:45 a.m. the DON stated the POC should include signs and symptoms of unisual bleeding and/or bruiging when a resident is receiving Cournadin. F 280 493.20(cf)(3), 483.10(kf)(2) RIGHT TO SS-D PARTICIPATE PLANNING CARE-REVISE CP 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 to changes in care and treatment to changes in care and treatment to	PHEFE	(EACH DEFICIENC)	' Must be preceded by Full	PHEFIX	CROSS-REPRESENTED TO THE APPROP		CONTENEN	
should include signs and symptoms of unusual bleeding and/or bruising when a resident is receiving Coursadin. F 280 493.20(d)(3), 483.10(k)(2) RIGHT TO F 280 SS-D PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetant 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. A comprehensive care plan must be developed	F 279	R4's Medication Ad [Physician's Orders Couradin po (oral medicated R4 had be mg by mouth daily. Review of R4's Plan 4/16/14, indicated a or intervention to an R4 was observed II 6/2/14, through 6/5 On 6/5/14, at 9:46 a stated R4 had bear RN-B further stated Couradin would be notes. RN-B confir problem statement siterventions related	ministration Record J dated 5/19/14, indicated y) as directed. A monthly e dated 6/1/14, to 7/1/14, star receiving Cournadin 7.5 n of Carc (POC) last reviewed a lack of a problem, outcome ddress the use of Cournadin. hroughout the survey week of (14. a.m. registered nurse (RN)-B n receiving Cournadin daily. I any side effects from the a documented in the progress mad R4's POC tacked a , an outcome and any					
	F 280 85=0	should include sign taleading and/or bruneding Coursell 493 20(d)(3), 483.1 PARTICIPATE PLATE The resident has thincompetent or other incapacitated under participate in plann changes in care an	is and symptoms of unusual dising when a resident is it. (KKK2) RIGHT TO NNIMG CARE-REVISE CP he right, unless adjudged arwise found to be if the laws of the State, to ing care and treatment or id treatment.	F 280			7-20-14	
							Toggether the transfer	

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	AND BYAN OLD CICARCOSION (31) AUGORDENCATION MINNER. (31) AUGORDENCATION (31) AUGORDENCATION MINNER.		A. SULDING			COMPLETED (x)I OWE SHIVEY	
	·	245392	e wko	on service of the ser		06/06/2014	
HANE OF F	ROMIGE OF SUPPLIER				HEET ADORESS, GITY, STATE, ZIP CODE		
Cook C	OMMUNITY HOSPITA	i canc			Southeast fifth Street Dok, MN 85723		
(XA) ID PREFIX TAG	SEACH DEFICIENC	Tement of Deficiences Y Must be preceded by Full Schoolyman information	IÚ FREFI TAG	*	STRANDERS PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD GROSS-REFERENCED TO THE AFTROP CEPTIFINGS)		DALL CHAINE FERRIN
F 280	F 280 Continued From page 10 comprehensive assessment; prepared by an interdisciplinary learn, that includes the altending physician, a registered surse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs.		F2	9Ü	F280:		•
				1	It is the policy of Cook Hospital ar	ook Hospital and	
			1		Nursing Home that the Comprehe	·	
i i				Ţ	Care Plan is consistent, accurate a		:
	and, to the extent p	wacticable, the participation of	-		followed by all nursing staff. Curr	ent	
		idents family or the resident's ; ; and periodically reviewed	1		revised policy titled, " Care Plan		
	and revised by a le	am of qualified persons after	, 1	:	Comprehensive- Nursing" was revised		
	हर्कती बद्धहरूकी स्तिति.			į	on 6/27/14 to include		:
	, ; ;				MDS Coordinator educated on Ca	are	:
	\$ 8 8		i a	3	Plan Comprehensive- Nursing po	licy on	
	1.	NT is not met as evidenced	e en de la composition della c		6/27/14.		
CANCEL THE COLUMN TO THE CANCEL T	; by: ' Based on observa	ition, interview and document		:	A full review of all resident Care I	Plans	:
singrecode	review, the locility	failed to ensure the care plan	* * *		is to be completed by goal date:		
	end of Desiver 2 to 1	aire appropriate positioning for 13) reviewed for gostioning.	and the state of t	j	7/13/14 to insure accuracy and		
	1 Par III ammaramanna Čiv	ಬಿ. ಫ್ರಿಕ್ ಕ್ಷ್ಮಿಕ್ ಪ್ರದೇಶದ ಬಿ. ಪ್ರಕ್ಷಿತ ಪ್ರದೇಶದ ಪ್ರವೀಸ್ತಿ ಪ್ರವೀಸ್ತಿ ಪ್ರವೀಸ್ತಿ ಪ್ರವೀಸ್ತಿ ಪ್ರವೀಸ್ತಿ ಪ್ರವೀಸ್ತಿ ಪ	- Francisco		consistency between records.		* * *
	Findings include:		1				ž.
	Bitā's deprosos a	tail yeammus sisongsib oxtron	1	;	Education of policy will be provid	led to	;
	provided on 6/4/14	, included diabeles,		,	all licensed nursing staff during		
		ie, polymyālgia flieomālica, throsis, lumbosacral	*	;	mandatory meeting on 7/9/14. S	tarr	
	92.5	porosis, longlerm use of			unable to attend will receive 1:1		
	sleraids, and abno	rmaily of gail with history of	ī	ì	review with DON.All new employ	rees	
	falls.		÷		will receive education		· · ·
		um Data Søl (MDS) daled	<u> </u>		'MDS Coordinator educated on		i
		R 13 had severe cognitive			6/27/14 that MDS must be consi	stent	
		ired extensive assist of one by, transfers, ambulation,	i 1		with Plan of Care.		f .
	loccondliber in whe	elchair, dressing, eating,	;		•		
HER CONTROL OF THE PROPERTY OF	frequently incombi	hygiens, and bathing, was want of bledder and bowal, hed anlly, and was at risk for skin			(Cont.)		

OEPARTMENT OF HEALTH AND HUMAN SERVICES

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MANTERIA PREFIA TAGE	CONTRACTOR OF SHIP	ALMENT OF DEFICIENCIES FMISTER PRECEDED BY FLAL SC DENTIFYING MFORMATIONI	ID PREFI TAI)		FROMBER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIENCE OF THE APPROPRIENCES OF THE APPROPR	D 65	CHAPETOIRA CHAPETOIRA CHAE	
F 280	Continued From pa	ige 11		28(•		:	
	brezidown.				Education of policy will be provi	ded to		
	The pressure ulser	care area assessment (CAA)			all licensed nursing staff during			
	daled WA1/14, indi-	evianekte beniupen ETA belge			mandatory meeting on 7/9/14.		:	
	assisi win all AUC: independently in bi	s, was able to tum self ed, and had a pressure redel	¥ 1 1		unable to attend will receive 1:1			
	matiress in ted. st	alionary chair, and tho			review with DON.		. `	
	wheelchair to aid a	a property		QAPI will be added by 7/15/14	to	į		
	further indicated R13 was frequently incontinent of bowel and bladder. The nutrition CAA dated				include process improvement for			
	1/29/14, indicaled	Rt3 was at incressed rek for	ţ		consistency of Comprehensive (•	
	skin breakdown related to lower most intake and weight.		:		Plan. This will provide ongoing	Jul 0		
					monitoring by DON, MDS and C	API		
	and 4/20/14, indica	s testing performed on 4/19/14 Scaled R13 tolerated being in the or two hours at a time while in wheelshair.			team assigned.	, ·	transport of automorphisms	
	daled 4/28/14, ind	Risk Braden Assessment icated R13's nutritional status an increased risk for the assure areas.					per en a a sun a sur	
	at risk for skin bre impaired cognition and directed staff R13 every two he plan directed staff nursing assistant independent with to tollet her every	ated 7/12/13, indicated R13 was akdown secondary to diabetes a, limited mobility, incontinense to turn, reposition or offload urs and as necessary. The care to toled wary 3 hours. The care alreats indicated R13 was repositioning and directed staff two hours. This information at with the care plan.	A Maria Cara Cara Cara Cara Cara Cara Cara				to a management of the substance and the substance of the	
	i repositionina time	3 p.m. RN-A said lite ofor R13 should be overy two d the care sheet said R13 was					Par Spring Fridomer and Berry	

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STANDARM OF CORRECTION STANDARM TO CORRECTION AND PLAN OF CORRECTION ON THE PLAN OF CORRECTION ON		IN PROVINCENSUPPLIERIGIA			MASTRACTION	ASS STACK (BEA) (STANKE)	
	·	245392	e Mini	E-Co-A-C-	and the second s	القال	19/2014
	ROWINS OR SUPPLIER	a. Čsnc		10 51	gt alxeress, city, state, 20° code Dutheast fifth street W., MN 55723		
enge pages (24) ID	SHEEPER ST	atement of Denoences 7 maist he preceded by flul 20 dentify his information;	ID PREF SAT	ià I	PROMIDER'S PLAN OF CORRECT SEACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE AFTEN DOPPORTORY)	€ <u>0</u> 62 <u>-</u>	Carie Competance (AE)
F 380	every two hours. I resident should be resident should be director of nursing tolerance feats and determination of a changes in R13's communicated by it in the care plant nursing assistants staff was directed daily, and updating which staff carry werfied the care particularly are plant which staff carry to the care particularly and updating which staff carry to the care particularly the care pa	epositioning and tolleting was tN-A stated she throught repositioned every 2 hours. on 6/5/14, at 12:30 p.m. the (DON)-B stated lissue performed on each resident and with changes and the care should have been notifying statin in report, pulting ing change book, emating the and rurses with the change, to check emails for changes githe care plan and care sheets, such shift they work. The DON dan directed staff to reposition are and the care sheets. It was independent with a DON verified she expected the care sheets.		280			
F 26 53*	dated 3/14, direct maintained in the each resident, shi to e-mail or leave coordinator if a cinformation does being done for the procedure furthe be developed, up nursing staff and carrent care plan	BERVICES BY QUALIFIED		F 382	See page 15 for this tag respo	nse.	and the second contract of the second contrac

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F 262	Continued From pa			262			
ಕ ಮು. ೩೯ಮು	The services provided b	ted or arranged by the facility by qualded parsons in sch resident's written plan of					
	•						
	: This REQUIREME! By:	NT is not met as evidenced	2 5		;		
	· Basad on observa review, oral care w	tion, interview and document as not provided as directed by r 1 of 3 residents (R13) are.	Charles of Carlotter Control o				
	Findings include:		2.5				
	included diabotes,	immary list provided on 5/4/14 Alzheimer's disease, anemia, atica, glaucoma, and	e i deserva particologica deservada per una				
	indicated R13 has and required exten personal hygiene a	s Set (MDS) dated 1/24/14, a severe cognitive impairment isive assistance of one staff for and bathing. The MDS no impairments of range of					
	dental care area æ 1/31/14, indicaled	cavity or broken testh. The ssessment (CAA) dated R13 required extensive activities of daily living (ADLs),	e a gar estadount producti				
	answers yea or no	questions, and has a few of lat have cracked or fallen out.	and the state of t				* * * * * * * * * * * * * * * * * * *
	decreased ability including brushing staff to set up suppressed cues for R1	ed 7/12/13, indicated R13 had o perform self care activities, teeth. The care plan directed plies for craf cares and provide 3 to complete tasks. The sare sheet dated 6/3/14.					
		tee man leest and directed	}		•		1

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statement and plan c	OF CENTERACHES F CENTECSION	(XI) PROVIDENSOPLIENCLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	CCRNFLED (x2) CWLE SARAEA	
		245392	B. WING			06	05/2014
	(EWCH DEFICIE)		ID FREST TAG	ti C	TREET ADDRESS, CITY, STATE, 21P CODE) SQUTHEAST FIFTH STREET OCK, MN 68723 FROMDERS PLANCE CORRECTS (EACH CORRECTIVE ACTION SHOW CROSS-REFERENCED TO THE ASPROA DEFISIENCY)	ĎŒ	ENTE ECONOMICE SON
F 282	dental consultation had a broken from hygiene was reconduring continuous from 7:06 a.m. with selection of the design of the desi	ral cares after each meal. The in dated 12/0/13, indicated R13 of looth and twice daily oral ammended. not observed to be performed a observations of R13 on 6/4/14, then R13 was seated in the ressed in the day room, through completed breakfast and was y room at 9:08 a.m. When R13 to bathroom at 9:55 a.m. by (RN)-A and nursing assistant yor's request, oral hygiene was be performed. Ing lunch at 12:45 p.m. R13 was reproom. At 1:20 p.m., NA-C rily had R13 for moming cares omed cares since then. On m. NA-B stated she had not bathroom or performed cares.		292	F282: It is the policy of Cook Hos and Nursing Home that oral hygic provided to each resident as their plan states. (Attachment H). R13 will receive oral hygiene as so in her care plan. All staff will be re-educated to the policy on July 9, 2014. QAPI will be developed by July 12 2014 by DON in regards to oral hand individualized care plans. Newly hired staff will receive oral hygiene education in orientation	ene is r care tated is 5, ygiene	
	3/14, directed all plan and to read outlined.	recedure for care plans dated nursing staff to follow the care and follow care plans as E CARE/SERVICES FOR . BEING	· · · · · · · · · · · · · · · · · · ·	200			
	provide the next	ust receive and the facility must assayy care and services to altain righest practicable physical,			to determine the second		

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		245192	B. 14842	NOTE AND ADDRESS OF THE PARTY O		05/2014
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(RA) ED PREFIX TAG	STATE OF THE STATE	Genent of Depatements Parist de Phiceses by Plail Ext Dentfyikg he ofikation)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION LEACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFEDENCY)	CAIC COMPLIANA [82]:
F 309	Continued From possible mental, and psychologoperation with the and plan of care.	age 15 psocial well-being, in e comprehensive assessmant	F:	106	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).	7-20-14
	by: Based on observanceview, repositionias directed by the (R13) reviewed for Findings include: R13's diagnoses provided on 6/4/4-Altheimer's diseasonal osleoa anondulosis osleoa	MT is not met as evidenced tion, interview and documenting assistance was not provided plan of care for 2 residents repositioning. The diagnosis summary list included diaboles, see polymyalgia rheumatica, ribrosis, lumitosacral eporosis, longtarm use of provality of gait with history of	A contract of the contract of		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 26 th , 2014 to insure consistency is improving. This process will be monitored through QAPI as created by the DON and MDS Coordinator.	
- National Annual Control of the Con	The annual Minim 1/24/14, indicated impairments, req staff for bod mobi locomotion in white talleting consonal	um Dala Set (MDS) daled I R13 had severe cognitive ured extensive assist of one lity, transfers, ambulation, selchair, dressing, eating, I hygiene, and bathing, was nent of bladder and bowel, had	the sign of the state of the st		DON will provide a mandatory inservice to all nursing staff on July 9 th , 2014 to re-educated in regards to duties and expectations including repositioning and following the Plan of Care as written.	

breskdown.

severe pain frequently, and was at risk for skin

The pressure ulder care area assessment (CAA) dated 1/31/14, indicated 6/13 required extensive assist with all ADLs, was able to turn self

independently in bed, and had a pressure retel mattress in bed, stationary shair, and the

Audits and plan

QAPI will be developed by July 15th,

2014 by DON in regards to cares including toileting and repositioning.

PRIMTED: 06/18/2014

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F 308	Continued From p	50a 16	£ 302) ;			
	forter indicated F	:13 was frequently incominent	\$!			
	nt howel and blad	ier. The nutrition CAA dated		on a			
	1/29/14, indicaled	R13 was at moreased risk for		ì			
		lans skelmi lisam rewol of ballsk	•	1			·
	weigls.			į			;
	end 4/20/14, indic same position for	esting performed on 4/19/14 ated R13 tolerated being in the two hours at a time while in	÷	C age of			
	bed and in the wh	aekhair.	1	:			1
A - About the state of	dated 4/28/14, inc	: Risk Braden Assessment Icaled R13's nutritional status an increased risk for lite ressure areas.		e program of the program of the second professional second			
issa. E. Chronosso (partytynyssestessessessessessessessessessessesses	at nak for akin bro impaired cognition incontinence. The	ed 7/12/13, indicased R13 was eakdown secondary to diabetes n, limited mobility and care plan directed furn, ad R13 every two hours and as					re and have been as constitution of the state of the stat
	was independent assist to tollet ev	alant care sheets indicated R13 with repositioning and directed ery two hours. The care sheet nt with the care plan.	ente escapitatorial e e aparação e e escape	, and the second			en plasmer it ver spoken i dende de
	7:05 a.m. to 9:55 when surveyor in of long sitting bir (NA)-B termatri	ously observed on 6/4/14, from a.m. (2 hours, 49 minutes) from (RN)-4 from edited registered nurse (RN)-4 from RN-4 and nursing assistant 13 mto the bathroom near the R13's bultocks area was red but		A REAL PROPERTY OF THE PROPERT			

marning.

On 6/4/14, at 1:20 p.m., NA-C, stated she lad not provided carea for R13 since golling hor up in the

FO-RM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO 0838-0391 CENTERS FOR MEDICARE & MEDICARD SERVICES (X3) DATE SLAWEY IXELANTITUME CONRELANCEMEN INTO PROMIDER/SUPPLIER/CUA MOMPLETED. INTEREST OF DEFICIENCES ILENTIFICATION NUMBER: A BUILDING. HIPT AN IS COURSELLING 66/05/2014 II. HORE 235392 STREET ALDRESS CITY, FIMIE ZA COSE HAME OF PROVICED OR SUPPLEA 10 SOUTHEAST FIFTH STREET COOK COMMUNITY HOSPITAL CAME COOK, MN 55727 PROVIDERS FLAN OF CORRECTION METERNO Jung SUMMERT STEETINENS OF DEFICIENCIES JEACH CORRECTIVE ACTION SHOULD BE PHECK CACH DEFECENCY MUST BE PRECEDED BY FLAX CATAG-REFERENCED TO THE APPROPRIATE 調料和 PECHLATORY OR LSC CENTEYING INFORMATION FREFIX. A. C. DEFICIENCY TAG F NI F 309 Continued From page 17 On 6/4/14, of 1:25 p.m. NA-8, stated she had not todeted R13 since this moming at 9:55 a.m. On 8/4/14, at 1:43 p.m. RN-A said the repositioning time for R 13 should be every two hours and verified the care sheet was inaccurate. On 6/4/14, at 1:50 p.m. RN-B and NA-A look R13 to the behiroom near the nurses station. R13's buttocks and coccyx were red, but blanched with touch, RM-8 stated R13's repositioning should be every two hours. During an interview on 6/6/14, at 12:30 p.m. the director of nursing (DON) stated tissue tolerance tests are parformed 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 stall in report, pulling it in the care planning change book, esnalling the nursing assistants and nurses with the change, sloff 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 version the care plan directed stall to reposition R 13 every has hours and the care sheets indicated the resident was independent with repositioning. The DON varified sine expected the staff to reposition residents according to the care plan. This 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

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(84) IB PHEFE TMO	EACH DEFICIENCY	Jewent of Obficiences Paust be preceded by full SI: Dientifying information;	ID PHEF TAG		PROMDERS PLAN OF CORRECTION SHOULD LEACH CORRECTIVE ACTION SHOULD CHOIS REPERENCED TO THE APPROP DEFICIENCY)	DRE	(16) Ciespi Piride Ofot
F 309	being done for the representation in procedure further in be developed, updated in the current care plans.	of match what is currently resident. The policy and idicaled the care plans were to ited and followed by the at all staff is knowledgeable of		103			
	assessments dated scale was to be don admission and a tis was to be done on reposition independing to be done on admissignificant charge; was to be updated	nd procedure for skin I 6/2006, indicated the Braden se with each resident on suc tolerance assessment all residents who cannot lently white in bed or when in a nd procedure directed testing salon, annually, or with a and the resident's care plan when a charge occurred LARE PROVIDED FOR	EL.	342			
	dally lwing receives	nable to carry out scrivities of it the necessary services to Ilion, grooming, and personal	A CANADA MANAGAMAN MANAGAM	e e de tras e estador de esperador de entre e el deservición de el deservición de el de entre entre el de entre entre el de en			A CANADA
	by: Essed on observa review the facility to	NT is not met as evidenced tion, interview and document siled to ensure craftygisne of 3 residents (R13) observed y sving (ADLs).	Andrew Andrewson (Andrewson (Andr				
	Findings include: R13's diagnosis su included diabetes,	rrmary list provided on 6/4/14 Atcheimer's diseasa, avemia,					

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CONTRACTOR DEPOSITIONS NO PLANCE COMMICTION

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CODX, MN 55721

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SUMMARY STATEMENT OF DENCIEDUSES REACHORECEMBY BUSTONE PRESIDENCES POST ARSALATORY CALLO TRATITARS INCOMMENCEN

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PREMARK REPORT OF CHILD CHEM SPACOL GEDERE CHAME ACTEON SHAVIND IN SECONDARY OF SELECTION OF THE APPROPRIE DEFCENCY

ready force.

P 312 Continued From page 19

polymyalgis metmalica, gattoma, and palgoginegaja

The annual Minimum Gala Set (MDS) dated 1924/14, adicated RTS has a severe cognitive imparment and required extensive essistance of mus staff for personal bygiene, and betting. The MUS indicated R13 had no impairments of range of mailton and had a cavity or broken teest. The dental cure men nanessmedt (CAA) døled 1/31/34, indicated 6/13 required extensive assistance with all activities of dally being (ACLS). answers yes or no genstions, and has a low of her cataral leads that have creaked or fallen out

The care plan dated W13/13, indicated 813 land decreased spility to perform self as a estivition. including boushing teeth. The care plan directed stail to get up supplies for oral cares and provide violate cuess for D13 to complete tasks.

The nursing assistant care sheet deted 6/3/14. sortespect 813 had her caun tress and directed start to provide oral cares after each meal

The deats, asseultation detect 129/13, indicates RT3 had a broken trent tooth and twice daily craft hydiana wan becommissiond

Chal unless were not observed to be performed. coning excitmatus observations on Sid/14, Rom 7.06 a.m. when RT3 was cressed and sealed in the wheelshair through 9:35 a.m. R13 completes breaklast and was brought to the day morn at 909 am What R13 was labely to the betwoon at (166 am by regulated nurse (RN) A and nessing assistant (NA)-B atal hypene was nist preserved to be provided

F312: F 310

> 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.

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.

7/20/14

PRINTED: 06/18/2014 FORM APPROVED OMB NO. 0958-0391

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		245292	u warac		i mili, roli figillare delikis, vened desementen i antanaktaman innangan annangan engana.	Oi	5M2(2014	
NAME OF PROVIDER ON SUPPLIER COOK COMMUNITY HOSPITAL CANC			CONTRACTOR OF THE	STREET AGGRESS, CRY, STATE, ZIP CODE TO SOUTHDAST PUTH STREET GOOK, MN: 55723			- Charles and the Control of the Con	
(A4) ID PHEF(X TAG	(EACH DEFICIENC	ac Inchailang Indamyana Antsi se begeded balantan Antsi se begeded balantan	id Free Tag		PROVIDERS FLAN OF CORRECT CHOSS-HERETHERS TO THE APPR OBTICIENCES		(PS) DOMESTICAN DOME	
	and stated she promoming, which inc socks were put on washed face, unde a warm wash cloth gave her water, an room. This was reconfirmed that this On 6/4/14, following brought to the day stated that she or and had not perfor 6/4/14, at 1:25 p.m taken R13 to the bance 9:55 a.m. On 6/5/14, at 10:4 provides craft hydrovides craft	wed on 6/4/14, at 11:30 a.m., vided cares for R13 in the fuded in sequence: dressed, changed brief, peri care, or arms, and under breasts with put her in the wheelchair, d brought her out to the day peated back to NA-C and she was the care provided to R13. Ig lunch at 12:45 p.m. R13 was room. At 1:20 p.m., NA-C y had R13 for morning cares med cares since then. On a NA-B stated she had not athroom or performed cares or ne works evening shift and ette, as R13 tends to be more IA-B carmed the care sheet and with her in her pocket. In m. registered nurse (RN)-B crashlygiene had not been to sheets. RN-B confirmed that staff should have followed that staff should have followed and hygiene.						
	plan and to read s cuttined.	and follow case plans as	٠					

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CKOK COMMUNITY HOSPITAL GANC

STREET ADDRESS, CITY, STATE, 21P CODE 10 SCUTHEAST FIFTH STREET COCK, MN 55723

Madio (Philip Tag ((PACH DEHIJENCY MUST BE PRECEIVED BY FULL SECULATORY OR LSC ICENTIFYING INFORMATION)
35×E	483.7W(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON

SLYWWY STATIMENT OF DEFICENCES

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, stall and the public.

This RECAUREMENT is not met as evidenced by:

Based of observation, interview and document review, the facility failed to maintain walls, doors, and/or cellings; and clean bathroom celling wents for 46 of 29 residents (R6, R34, R29, R25, R26, R20, R7, R19, R4, R31, R13, R17, R32, R107. R1, R108) in the facility.

Findings include:

On 6/5/14, at 12:37 p.m., an environmental four was completed with the Environmental Services Director (ESD). The following conserns were abserved:

Ré's room had an area (approximately 4 inches x 6 inches) above the headboard which was poeting and gouged. The bathroom celling vent had a thick layer of dust. R6 shared the bathroom with R4 and R28. The ESD verified the areas needed repair.

RQ4'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 vented the areas needed repair. R34 shared a bathroom with R31 and 107.

R29's bathroom ceiling vent had a thick layer of dust. The ESD verilled the area needed clearing.

F465: FASS

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.

PROMIDER'S PLAN OF CORRECTION

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Per Fnvironmental 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.

Cleaning of Vents was placed on the Housekeepers Extra Duty checklist (attachment E)

PRIMTED: 08/18/2014 FORM APPROVED OWS NO. 0538-0391

STATEMENT OF DEFICIENCIES OND PLAN OF CORRECTION

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II WEEK

06/05/2014

NAME OF PRODUCTOR OR SUPPLIES

COOK COMMUNITY HOSPITAL CANC

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SLAMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) id Freim Tag PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHILLD BE CROSS-HIPCHENCED TO THE APPROPRIAT () QUINCIGNOT)

pej Completion Dere

F 465 Continued From page 22

R25's ball-morn celling vent had a thick layer of dust. The ESD verified the area needed describe.

R2R's bedroom wall had scraped paint along side. and behind the bed. The bathroom ceiling world had a thick layer of dust. The ESD verified life area needed cleaning. R28 thisted a bathroom with R6 and R4.

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.

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.

R.19's baltimom ceiling vent had a thick layer of dust. The ESD verified the area needed obtaining.

R4's wall, above the headboard, was chaped and gorged. The bodside stand trim along the bottom drawer was taling oif. The closet door was scrapped. The ESD verified the areas needed repair.

R31's calling tile was stained alight brown. The ball-room ceiling yent had a thick layer of dust. The ESD verified the areas needed cleaning. R31 shared a bathroom with R34 and R107.

Ri3 and 17's room wall near the door frame had peeling wall paper. The closet door was scraped. The ball-room, 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 vention the west recorded 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.

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.

Maintenance repairs are currently underway with a target completion date of: July 20th, 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.

PRINTED: 06/18/2014 FORM APPROVED OMB_NO. 0918-0391

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06/05/2014

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COOK, MAY 55723

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F 465 Continued From page 23

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.

R1's calling life 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 clearand.

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 vants were to be cleaned twice weekly and acknowledged the vants in the facility had not been cleaned for weeks.

F 465 (Cont.)

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.

Attachment A

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

EFFECTIVE DATE: 06/27/14	REVISION:
SUBJECT: Privacy and Confidentia	
A TURNETON.	**************************************
clinical records. Personal privacy include	personal privacy and confidentiality of his or her personal and des accommodations, medical treatment, written and telephone and meetings of family and resident groups.
PROCEDURE:	
Right to privacy means that the resider private and that this privacy should incactivities, auditory privacy.	nt has the right to privacy with whomever the resident wishes to be clude full visual and to the extent desired, for visits or other
an individual requires assistance, author	esidents in a manner that maintains the privacy of their bodies. If orized staff should respect the individual's need for privacy. Only will be present when treatments are given.
Staff will pull privacy curtains, close declothing or draping to prevent unnecessand services.	oors, or otherwise remove residents from public view and provide ssary exposure of body parts during the provision of personal care
privacy as it relates to their medical are examination and treatment are confident treatment such as: blood glucose monitorial like to go to a private area. If the	at residents and patients shall have the right to respectfulness and and personal care program. Case discussion, consultation, ential and will be conducted as such. When administering itoring, insulin administration staff will ask the resident if they are resident wants the treatment administered in a common area, the residents around the individual receiving the treatment if it is atment in their presence.
in Airiday ality and cultural identity as	nts shall have the right to every consideration of their privacy, related to their social, religious, and psychological well-being. of a resident's room by knocking on door prior to entering room, rly inadvisable.
Administrative Approval:	Date:

HHACKWAT 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



POLICY:

- The resident has the right to be free from any physical restraint imposed for purposes of discipline, 1. convenience and not required to treat resident's medical symptoms.
- If a resident becomes disturbed or difficult behavior creates a management problem, due to the presence 2. 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.
- The least restrictive device will be utilized. 3.
- Resident will have a Pre-Restraining Assessment Completed as well as an ongoing review for the 4. 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:

- Physical Restraints: Any manual method or physical or mechanical device, material or equipment 1. 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).
- Physical restraints include but are not limited to: leg restraints, arm restraints, hand mitts, soft ties or 2. vests, lap cushions and lap trays the resident cannot remove easily.
- Physical restraints also include practices which meet the definition of a restraint such as tucking in a 3. 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.
- Bed rails are considered a restraint if they restrict freedom of movement. If the bed rail is used solely to 4. assist the resident in turning or to help the resident get out of bed, then the bed rail is not used as a restraint.
- Medical symptoms that warrant the use of restraints will be documented in the resident's medical record, 5. 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. <u>Informed Consent for use of Restraints form</u> (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:	ADMINISTRATIVE APPROVAL:	DATE:
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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:

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.

	-1-1-1	1 84 1 EE	AND MENTAL CONSIDERATIONS		
ENTAL STATUS	YES	NO	AND MENTAL CONSIDERATIONS VISION/MUSCLE CONTROL GOOD FAIR POOR	NO	NE L-
Alert			Vision (R-right; L-left) R- L- R- L- H- L-	+	
Short attention span			Muscle control	Colored Services	and a second
Disoriented		Sample State State	PARALYSIS/PARESIS - (✓ if present) Arm □ Right Hand □ Right Leg □ Right Foot □ Right		
ALANCE (When Sitting)	YES	МО	Atti d right hate a right		
Falls forward		<u> </u>	POTENTIAL MEDICAL FACTORS AFFECTING BEHAVIOR	YES	NO
Falls/leans sideways			Medication change or addition in past month?		
🗅 Right 🔾 Left 🗘 Both			Possible infection?		
Slides down	\vdash	<u> </u>	Dehydration or electrolyte imbalance?		
SlumpsSlumps	YES	NO	Acute hypoxia?		
ECOVERY OF BALANCE (While Sitting) Forward	120		Toyin drug levels?		
Backward			Change in baseline vitals?		
Sideways			Recent trauma?		
MBULATION	YES	NO	Other:		
Unsteady on feet					
Loses balance			TOTAL TOTAL PROPERTY.	YES	NO
History of falls			HAS RESIDENT EXPERIENCED A RECENT:	'	
Foot problems		<u> </u>	Change of roommate?		
Takes short steps,,,,		 	Room change?		
Steps on own feet			Transfer?		
Leans to side		+	Care giver or staff change?		
Leans backward		 	Other:		
Leans forward		1	Other		
W/C mobility		1			
Other:				***************************************	KS145 (CRITER
FMATION		317/1-7	DIMENTAL AND SOCIAL CONSIDERATIONS		
EWOTION		CTOP	YES NO POTENTIAL CONTRIBUTING BEHAVIORAL FACTOR	YES	NO
OTENTIAL CONTRIBUTING BEHAVIO	TALIA	01011			
Glasses: ill-fitting, dirty or missing	- (-		Can not comprehend surroundings		
Dentures: improper fitting or uncomfortal	ole	**********			
Ears impacted with cerumen	*************	************	Recent loss due to own illness		
Hearing aid malfunctioning		*************	Recent death/loss of a loved one	<u> </u>	
Needs to go to the bathroom	***************************************	************	Recent change in financial status		-
Has wet or soiled clothing, bed linen		*************	Loss of self-control		<u> </u>
Is hungry or thirsty	************				
Needs position changed; is cold/warm			Experiencing feelings of loneliness or isolation		-
Environmental barriers					
Misinterprets words, sounds	**********				
Feels threatened by other residents					
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		V Date			
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NTERDISCIPLINARY TEAM EVAL Plan of Care Updates	UATION s; If yes, gth of ti Sig	, Date _ me to b gnature/	e / /Recommendations:	/	/

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

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 wellbeing. 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.

Preparation:

- 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.

Special Considerations:

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 Assessn	nent Policies for ancillary departments.
Administrative Approval:	Date:

Attachment D

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

*****	*****	EDATE: 06/27/14 ***********************************
SUBJE	CT:	Environmental Conditions
AUTH	OR:	**************************************
POLIC resider	CY: TI	he facility must provide a safe, functional, sanitary, and comfortable environment for ff and the public.
	Main frame dama Upon work Whee repla	tenance department will perform a weekly environmental inspection of all doors, door es, windows, floors, floor non-skid strips, walls, ceilings and light fixtures. Identification of age and repair will be noted on the weekly room inspection checklist for maintenance. In discharge of residents in the Nursing Home, the Charge nurse will notify maintenance via a order for inspection and repairs of unit. The classes are in place on all regular beds to prevent marring of walls. Wheel Casters will be aced as necessary. O beds have braces between wheels and walls to prevent the bed from damaging the wall. Sekeeping will be assigned weekly to dust vents and all high area surfaces.
Adm	inistra	ative Approval: Date:

Attachment E

Cook Hospital & Nursing Home HIGH AREA DUSTING CHECKLIST WEEKLY

Place a check in the box after cleaning is complete.

	The state of the s
	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.

		CAND HUMAN SERVICES S MEDICAID SERVICES	-	£1200	RINTED, 06/18/201 FOIEM APPROVE MB NO 0038-039
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LABORATORY DIRECTOR'S OR PROVIDENSUPPLIER REFRESENTATIVE'S SIGNATURE

DESCRIPTION OF THE PERSON OF T

Any delicionary statement ending with an exercise (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safegrands provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the lindings stated above are discissable 90 days tolowing the date of among whathat or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are discissable 14. days following the date these documents are made available to the facility. If unfollowing are sixed, an approved plan of correction is requisite to continued program participation.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORK) 08/192014 MAPPROVED): 0938-0391
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	By email to				completed or will be completed assigned dates:	on	
	Marian.whitney微s	ace, and us			fully Committee DNI/DONINIII		
	THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date.				Julie Gerzin, RN/DON-NH		
	responsible for cor	or title of the person rection and monitoring to ence of the deficiency.					
	Cook Hospital C & WC is a 1-story building with a pactial 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.						
	facility has a company smoke detection in that is monitored I notification. The fa	y fire sprinkler protected The slete fire alarm system with a spaces open to the corridor, or automatic fire department scility has a licensed capacity of a census of 26 at the time of					

		HIANO HUMAN SERVICES E & MEDICAID SERVICES	v		PRINTSO, 06/18/20 FORM APPROVI OMB NO 0938-03
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K 000	Continued From p	inge 2	K 00	0	
K 050 SS=F	Fire drills are held varying conditions. The staff is familia that drills are part Responsibility for assigned only to qualified to exercise and ucted between	OT met as evidenced by: AFETY CODE STANDARD I at unexpected times under at treast quarterly on each shift, at with procedures and is sware of established routine, planning and conducting drills is competent persons who are seleadorship. Where drills are an 9 PM and 6 AM a coded by be used instead of audiale 2	K 65	It is the policy of Cook Ho Nursing Home to hold fire accordance with state and standards while following Safety Code. Refer to Fire Evacuation Plan (attachm Environmental Services D performed Fire Drills x2 o afternoons, x 1 midnights the month of June, 2014.	e drills in d federal the Life and ent F). irector has n days, x1 s throughout
	Based on review interview, it was donot conducted at 19.7.1.2. This det occupants in its the Findings include:	is not met as evidenced by: of available documentation and letermined that fire driffs were as required by LSC(00) Section icient practice could affect all is event of a fire emergency.		continue on all three shift regulation. This will be pe monitored by the Environ Services Director through specific interventions and schedules determined thr project.	rformed and mental QAPI with auditing
	approximately 10	conclusion of the inspection, at 30AM, based on a review of decumentation it was		Environmental Services D	irector has

avaitable fire dell 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.

This deficient practice was confirmed by the

implemented as of June 11, 2014 the

Fire Drill Report Form (Attachment G)

standards for proper documentation.

which meets Life Safety Code

CEPARTMENT OF HEALTH AND HUMAN SERVICES - CENTERS FOR MEDICARE & MEDICAID SERVICES -

PRINTED: 06/10/2014 FORM APPROVED OMB NO. 0938-0391

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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.

Cook Community Hospital C&NC June 18, 2014 Page 2

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

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