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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: GV67

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

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/18/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Gary Nederhoff, Unit Supervisor — 01/22/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 02/03/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 02/10/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/21/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245392

February 3, 2015

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

Dear Ms. Debevec:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective January 8, 2015 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
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 22, 2015

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

RE: Project Number S5392025

Dear Mr. Vogt:

On December 15, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 4, 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 January 18, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 8, 2015 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 December 4, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 8, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 4, 2014, effective January 8, 2015 and therefore remedies outlined in our letter to you dated December 15, 2014, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245392	A. Building B. Wing	1/18/2015

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	(Y4) Item	(Y5) Date
ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **12/04/2014**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **12/04/2014**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **12/08/2014**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **12/08/2014**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **01/05/2015**	ID Prefix **F0247** Reg. # **483.15(e)(2)** LSC	Correction Completed **12/08/2014**
ID Prefix **F0252** Reg. # **483.15(h)(1)** LSC	Correction Completed **12/30/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **12/30/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **12/08/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/KJ	1/22/2015	10160	1/18/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/4/2014			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245392	A. Building B. Wing **01 - MAIN BUILDING 01**	1/8/2015

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0061	**12/22/2014**	ID Prefix Reg. # **NFPA 101** LSC K0147	**01/08/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/KJ	1/22/2015	03005	1/8/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 12/4/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GV67

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00586

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/04/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE NE II 12/30/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 01/15/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
December 15, 2014

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

RE: Project Number S5392025

Dear Mr. Vogt:

On December 4, 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:

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

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

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

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

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

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

DEPARTMENT CONTACT

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

Patricia Halverson, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: Patricia.halverson@state.mn.us

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 13, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 13, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 4, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 4, 2015 (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 an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulations Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

5392s15epoc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING _____ B. WING _____	12/04/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 167 SS=C	Census: 23 483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post the most recent survey results in a location readily accessible to residents. This deficient practice had the potential to affect all 23 residents residing in the facility.	F 167	F0167: 6/2014 Survey Results were immediately lowered by the D.O.N to the bottom portion of the Resident Bulletin Board in the NH upon discussion with MDH	12/4/14

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

Electronically Signed | 12/22/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING _____ B. WING _____	12/04/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 167	Continued From page 1 Findings include: During the initial tour on 12/01/14, at 2:07 p.m., the facility's most recent survey results were noted hanging on a bulletin board in the corridor next to the nursing station. The results were tacked high up on the activities bulletin board above head level for a resident in a standing position, and not accessible to residents in a wheelchair. Observation on 12/02/14, at 1:32:20 p.m., revealed the survey results were again noted in the same position, above head level on the activities bulletin board. Observation on 12/03/14, at 8:15 a.m., revealed the survey results remained high up on the bulletin board above activity calendar, not readily visible or accessible to residents without assistance. During interview on 12/03/14, at 11:20 a.m., the Director of Nursing (DON) visualized the survey results posting in its location on the bulletin board and stated the results were too high up for residents to visualize, and should be at wheelchair level. The facility policy, entitled Resident Rights-Examination of Survey Results, last revised 2/08, indicated the survey results are posted in the nursing home at eye level for a resident whom is confined to a wheelchair to have accessibility to.	F 167	surveyor. D.O.N also created a large border, brightly colored behind the survey results with the words, "DO NOT RELOCATE FROM THIS POSITION DUE TO STATE REGULATIONS". Staff were immediately re-educated by D.O.N via email as well as in shift report that survey results are to remain as hung on the board. D.O.N. will include this training with all new nursing hires as well as with annual education for all nursing and nursing home employees. Placed on daily round sheet for D.O.N to monitor placement of survey results. In addition all staff will be re-educated in person in State Correction meeting on 12/30/14.	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE	F 176		12/24/14

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F 176	Continued From page 2 An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess self-administration of a nebulizer for 1 of 1 residents (R27) reviewed for self-administration of medications. Findings include: On 12/03/14, at 7:57 a.m. licensed practical nurse (LPN)-C was observed to administer medication (albuterol 2.5 milligrams [mg]/3 milliliters [ml] solution) into a nebulizer medication container. LPN-C then turned on the nebulizer machine, and handed the nebulizer mouthpiece to R27. LPN-C left R27 sitting alone in her room holding the nebulizer treatment. R27's quarterly Minimum Data Set (MDS) dated 9/04/14, identified diagnoses that included congestive heart failure and chronic obstructive pulmonary disease (COPD). The MDS also indicated R27 was cognitively intact. R27's care plan dated 12/04/14, directed care staff to administer medications as ordered. R27's physician orders signed 11/11/14, directed albuterol 2.5 mg/3 ml solution inhalation four times daily, but lacked an order to self-administer the medication.	F 176	F-0176: It is the policy of the Cook Hospital and Nursing Home to provide an assessment to a resident upon admission as well as quarterly in regards to determining their ability to self administer medications. The Nursing Home Policy titled, "Self Administration of Medications" was updated on 12/05/14 and reads as follows: An individual resident may self-administer drugs if the Interdisciplinary Team including review with the physician has determined that this is safe. All nebulized medication will follow this policy including determining if the resident is able to hold the hand held device and be left alone with the nebulizer running during the course of delivery of the medication. This will be noted in the IDT/Physician review form and noted in the EMR on the form titled, "Self Administration of Medications". The comprehensive Care plan will include the self administration decision under the problem of "Medication Management". This will include ongoing monitoring and any specific self administration directions.	

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F 176	Continued From page 3 Self-administration of medications assessment dated 9/9/14, indicated R27 has not expressed a desire to self-administer medications. On 12/03/14, at 7:57 a.m. LPN-C stated R27 had a self-administration order for the nebulizer treatment and could remain alone to self-administer the nebulizer treatment. On 12/03/14, at 9:00 a.m. registered nurse (RN)-A stated there was no order for self-administration of the nebulizer. On 12/04/14, at 10:49 a.m. the director of nursing (DON) verified there was no order for self-administration of the nebulizer. The facility policy and procedure on Self Administration of Drugs dated 1/99, specified upon admission and quarterly each resident must be asked his/her preferences to self-administer drugs. If the response is no, the resident has exercised this right.	F 176	The ongoing monitoring will be completed quarterly during the care conference and shall be noted on the Care conference Summary sheet in the resident's EMR. All nursing staff were immediately re-educated via email and will attend a mandatory retraining on 12/30/14 by the D.O.N. All new licensed nurses hired will receive this education during orientation. R27 was immediately assessed for the ability to self administer her scheduled nebulizer medication. It was determined that the nurse will keep the medication at the nurses station and will provide to the resident at the appropriate times as ordered by the physician. The resident has been assessed appropriate to hold the hand held nebulizer delivery device throughout her nebulized medication delivery and is able to turn the nebulizer machine on and off if necessary. Resident is able to be alone in a room while delivery of nebulized medication is occuring. Nursing will ensure the medication has been fully delivered after the approximate 10-15 minutes which is standard delivery time. ADDITIONAL INFORMATION RELATED TO REJECTED POC: A QAPI was immediately initiated to insure ongoing monitoring of appropriate determination of self administration is initiated with admissions and/or residents request to do so. Will insure the self administration of medication assessment is performed with each determination by	

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F 176	Continued From page 4	F 176	chart review as well as interview with licensed nursing staff by the D.O.N. As noted above the ongoing monitoring will also be completed by the MDS during quarterly care conferences and changes in condition. The QAPI will also include audits quarterly of the completion of the care conference review for self administration of medications compliance and competency to continue when indicated. The review will include this documentation by the D.O.N as well as with changes in condition on residents whom self administer to insure ongoing compliance through this monitoring.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the	F 225		12/8/14

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F 225	Continued From page 5 State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure potential allegations of mistreatment were immediately reported to the state agency for 1 of 1 residents (R7) reviewed for abuse. Findings include: R7'ss Diagnoses Summary undated, identified diagnoses that included cerebral vascular accident (CVA - commonly known as stroke). The annual Minimum Data Set (MDS) dated 11/14/14, indicated R7 had severe cognitive impairment and required extensive assistance of two staff for bed mobility, total assistance of two staff for transfers, and extensive assistance of one staff for dressing and personal hygiene. On 12/02/14, at 9:25 a.m. R7 stated he received rough treatment during evening cares. R7 stated	F 225	F225: It is the policy of the Cook Hospital to follow the Vulnerable Adult Maltreatment Prevention Plan which states that if an incident occurs to a resident, the RN or LPN shall document in the chart, notify MD if applicable and notify family or representative of the resident. Then the concurrent procedure noted on page 6 of the plan under #6 part a. will be followed. The mandated reported who suspects resident abuse or neglect shall then immediately report the maltreatment to the OHFC and CEP. The report was given to the D.O.N by the surveyor whom performed a resident interview that the resident reported to her that he was treated, "roughly during HS cares". The D.O.N proceeded to ask the	

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F 225	Continued From page 6 he did not report this to the staff, but did report it to his wife. On 12/02/2014, at 3:06 p.m. the director of nursing (DON) was informed of R7's potential allegation of rough treatment by staff during evening cares. On 12/03/2014, at 12:59 p.m. the DON stated she had not reported the potential allegation of mistreatment to the state agency. The DON further stated she was investigating and would report once the investigation was complete. The Vulnerable Adult Maltreatment Prevention Plan policy and procedure dated September 2013, directs staff who suspect resident abuse or neglect to report immediately to the state agency.	F 225	surveyor what the resident meant by roughly, when it occured and by whom. She only reported a staff member name and that R7 had not reported it to staff, but did report it to his spouse. The D.O.N. proceeded to attempt to interview the resident to obtain details to submit to OHFC and CEP. R7 was already out of the facility on an all day outing with activities. D.O.N immediately contacted his spouse via telephone whom stated he had never reported anything of the sort to her. D.O.N still required more information from the resident so had to wait until the interview could be performed on the next morning. Upon the interview with R7, D.O.N was informed by the resident that what he meant by roughly was that he was "rushed" during his cares at HS on one evening. D.O.N reviewed this with the survey team after they asked if the report was filed and it was determined that the D.O.N would file the VA and it was filed at that time. D.O.N than continued to perform the standard internal investigation with multiple residents who were cognitive enough to voice any concerns they had regarding the named caregiver. No concerns were identified regarding this caregiver or any caregiver for that matter. OHFC determined no further action was needed after the internal investigation was submitted. Details of a VA or potential VA must include what is meant by a statement made by a resident to determine if abuse or suspected abuse occured. In this case the resident was not available for	

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F 225	Continued From page 7	F 225	interview, the surveyor did not collect any details for the D.O.N to submit an intial VA report and the spouse denied ever hearing about this treatment as the resident first reported to the surveyor. The D.O.N had no facts to submit immediately. In the future the policy will be followed as it was and as it is written to report an incident immediately to the OHFC and CEP. All staff in the nursing home receive orientation and training upon hire and annually to the policy Vulnerable Adult Maltreatment Prevention Plan (see attachment). Nursing staff have been educated to this specific tag and in the future will report immediately any details which they collect. ADDITIONAL INFORMATION RELATED TO REJECTED POC: The mandated reporter whom receives the information from a resident for real or suspected abuse in any form as per the policy indicates will immediately report the alleged allegation to the OHFC, and CEP. This information will also then be immediately provided to the ADministrator/CEO as well as the D.O.N to insure an immediate internal investigation is performed thoroughly and submitted to the OHFC and CEP. This policy was updated and reviewed immediately with all staff as well as signed indicating a full understanding of the Vulnerable Adult Maltreatment Prevention	

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F 225	Continued From page 8	F 225	Plan is followed fully. QAPI was immediately initiated by the D.O.N to insure that any future VA's have been filed immediately to insure the resident rights are protected, with the internal investigation following as indicated by the D.O.N or designee. D.O.N is immediately re-educated per review of the Vulnerable Adults Act and will immediately report any comments of mistreatment in the future.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow their policy to ensure potential allegations of mistreatment were immediately reported to the state agency for 1 of 1 residents (R7) reviewed for abuse. Findings include: The Vulnerable Adult Maltreatment Prevention Plan policy and procedure dated September 2013, directs staff who suspect resident abuse or neglect to report immediately to the state agency. R7 's Diagnoses Summary undated, identified diagnoses that included cerebral vascular	F 226	It is the policy of the Cook Hospital to follow the Vulnerable Adult Maltreatment Prevention Plan which states that if an incident occurs to a resident, the RN or LPN shall document in the chart, notify MD if applicable and notify family or representative of the resident. Then the concurrent procedure noted on page 6 of the plan under #6 part a. will be followed. The mandated reported who suspects resident abuse or neglect shall then immediately report the maltreatment to the OHFC and CEP. The report was given to the D.O.N by the	12/8/14

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F 226	Continued From page 9 accident (CVA - commonly known as stroke).The annual Minimum Data Set (MDS) dated 11/14/14, indicated R7 had severe cognitive impairment and required extensive assistance of two staff for bed mobility, total assistance of two staff for transfers,and extensive assistance of one staff for dressing and personal hygiene. On 12/02/14, at 9:25 a.m. stated he received rough treatment during evening cares. R7 stated he did not report this to the staff, but did report it to his wife. On 12/02/2014, at 3:06 p.m. the director of nursing (DON) was informed of R7's potential allegation of rough treatment by staff during evening cares. On 12/03/2014, at 12:59 p.m. the DON stated she had not reported the potential allegation of mistreatment to the state agency. The DON further stated she was investigating and would report once the investigation was complete.	F 226	surveyor whom performed a resident interview that the resident reported to her that he was treated, "roughly during HS cares". The D.O.N proceeded to ask the surveyor what he meant by roughly, when it occured and by whom she only reported a staff member name and that R7 had not reported it to staff, but did report it to his spouse. The D.O.N. proceeded to attempt to interview the resident to obtain details to submit to OHFC and CEP. R7 was already out of the facility on an all day outing with activities. D.O.N immediately contacted his spouse via telephone whom stated he had never reported anything of the sort to her. D.O.N still required more information from the resident so had to wait until the interview could be performed on the next morning. Upon the interview with R7, D.O.N was informed by the resident that what he meant by roughly was that he was "rushed" during his cares at HS on one evening. D.O.N reviewed this with the survey team after they asked if the report was filed and it was determined that the D.O.N would file the VA and it was filed at that time. D.O.N than continued to perform the standard internal investigation with multiple residents who were cognitive enough to voice any concerns they had regarding the named caregiver. No concerns were identified regarding this caregiver or any caregiver for that matter. OHFC determined no further action was needed after the internal investigation was submitted. Details of a VA or potential VA must	

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F 226	Continued From page 10	F 226	include what is meant by a statement made by a resident to determine if abuse or suspected abuse occured. In this case the resident was not available for interview, the surveyor did not collect any details for the D.O.N to submit an intial VA report and the spouse denied ever hearing about this treatment as the resident first reported to the surveyor. The D.O.N had no facts to submit immediately. In the future the policy will be followed as it was and as it is written to report an incident immediately to the OHFC and CEP. All staff in the nursing home receive orientation and training upon hire and annually to the policy Vulnerable Adult Maltreatment Prevention Plan (see attachment). Nursing staff have been educated to this specific tag and in the future will report immediately any details which they collect immediately. ADDITIONAL INFORMATION RELATED TO REJECTED POC: The mandated reporter whom receives the information from a resident for real or suspected abuse in any form as per the policy indicates will immediately report the alleged allegation to the OHFC, and CEP. This information will also then be immediately provided to the ADministrator/CEO as well as the D.O.N to insure an immediate internal investigation is performed thoroughly and submitted to the OHFC and CEP. This policy was updated and reviewed	

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F 226	Continued From page 11	F 226	immediately with all staff as well as signed indicating a full understanding of the Vulnerable Adult Maltreatment Prevention Plan is followed fully. QAPI was immediately initiated by the D.O.N to insure that any future VA's have been filed immediately to insure the resident rights are protected, with the internal investigation following as indicated by the D.O.N or designee. D.O.N is immediately re-educated per review of the Vulnerable Adults Act and will immediately report any comments of mistreatment in the future.	
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident choices were offered and honored for bathing frequency and/or bedtimes for 4 of 4 residents (R27, R25, R18, R23) reviewed for choices. Findings include: During an interview on 12/1/14, at 6:34 p.m. R27 stated she prefers a shower at least twice weekly,	F 242	F242: It is the policy of the Cook Hospital and Nursing home to make resident's aware of their right to participate in their care plan and treatment as per the following policies: Resident Rights- Participation in Planning Treatment and Resident Rights- Self Determination and Participation. This does include planning for their care needs and preferences such as showers/baths	1/5/15

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F 242	Continued From page 12 but only gets one shower weekly. R27 stated she has not asked for more than one weekly, but that the facility has not asked her how many baths she would like. In addition, R27 stated she would prefer to go to bed by 7:00 p.m. and watch what she wants to watch on her TV, but they do not put her to bed until about 9:00 p.m. The quarterly Minimum Data Set (MDS) dated 9/4/14, indicated R27 was cognitively intact and required extensive assist with one staff for transfers, wheelchair locomotion, dressing, personal hygiene, bathing, and bed mobility. The Care Area Assessments (CAA) dated 6/9/14, regarding cognitive and activities of daily living (ADLs) indicated R27 was able to communicate her needs to staff and that staff are to offer her choices and allow her to make decisions as she is able. The care plan revised 5/30/14, indicated R27 had mobility deficits with transfers, wheelchair mobility and bed mobility. The care plan directed staff to provide extensive assist of two staff to transfer into the bathing chair, and extensive assist of one staff to bathe. The Care Plan Reference Sheet used by the direct care staff, indicated R27 was to receive a bath on Wednesdays. The bath schedule indicated R27 was to receive a bath on Wednesday a.m. On 12/3/14, at 12:00 p.m. R27 was observed sitting in dining area and then moved to her room. R27's hair had been brushed back, and she had clean clothes on. R27 stated she had not received her shower today, though she knew this was her bath day. R27 stated she hoped she would get one later that day.	F 242	and choices surrounding that process such as: type of bath/shower, frequency, and time of day. These policies also encompass the residents right to voice preferences for assistance with AM and HS cares each day. The Nursing Admission Assessment was updated in the EMR to reflect very specific questions regarding bathing. New questions now include: preference for shower/bath, time of day preferred/requested, and frequency requested. This is also now added to the EMR form titled, "Care Conference Summary " which is the quarterly care conference form reviewed with each resident and/or their designee during their care conference. The above forms were also updated with the following question regarding AM/HS preference times for getting up and going to bed. Do you have a preference of time for waking? Do you have a preference of time for getting ready for bed in the evening? Each residents comprehensive care plan will reflect their specific preferences as well- with a January 4th, 2015 completion date for updates which will have included 1:1 interview with every resident to determine any specific individual preferences. All nursing staff were educated immediately via email regarding the above updates made to forms in the EMR and	

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F 242	Continued From page 13 During an interview on 12/1/14, at 6:04 p.m., R25 stated she received a bath or shower one time weekly and if she were at home, she would bathe more frequently. R25 stated if more baths were offered at the facility, she would take more. The annual MDS dated 8/21/14, indicated R25 was cognitively intact and required physical assistance of one staff for bathing. R25's care plan dated 8/27/14, indicated the goal for bathing and hygiene was to maintain optimal bathing ability. The care plan directed staff to provide extensive assist of one staff to bathe. The facility bath schedule and the care plan reference sheet used by direct care staff indicated R25 was to receive a bath on Wednesdays. During an interview on 12/03/14, at 8:16 a.m., registered nurse (RN)-A stated residents know they can ask for more than one bath per week, but stated residents do not ask, and they only have one resident who has asked. RN-A verified they do not ask the resident if they want more frequent baths. RN-A stated bedtimes are supposed to be resident choice, but she does not know if they are being asked. During an interview on 12/4/14, at 9:30 a.m. nursing assistant (NA)-B, who gave the baths, stated when residents are admitted, the residents are scheduled for one unless they or the family request more. When residents request another bath, she informs the nurse, who then informs the scheduler and it gets added. NA-B denied that neither R25 or R27 have requested more frequent baths. During an interview on 12/4/14 at 9:48 a.m., NA-A stated residents verbalize when they want to go to	F 242	the MDS coordinator was re-educated and updated as well on her role with the care plans and the care conferences. All staff will also receive in person training on 12/30/14. Education is now included in the new hire orientation as well performed during orientation. Staff were also educated that if a resident makes a request for additional showers/baths and or a change in their preference to immediately notify their charge nurse who can update the bath schedule and notify the MDS/PPS nurse whom can update the Plan of care. R27 stated to surveyors upon interview that she would prefer showers at least twice weekly, and that she was not asked if she wanted more than one shower per week. She also stated that she wants to be in bed by 7:00pm to watch her own T.V. and that currently she is not put to bed until approximately 9pm. Upon interview by D.O.N on 12/5/14 with resident she does choose to have showers twice weekly. This was noted in her chart, updated on her comprehensive plan of care, placed on the updated shower list for staff awareness and an email was sent to all staff as well regarding the updated kardex and care plan for R27. R25 was interviewed by D.O.N on 12/5/14 based on surveyor findings and stated that she is happy with one shower per week and does not want any more at this time. This will be reviewed again during her quarterly care conference.	

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F 242	Continued From page 14 bed and that it is often after the 7:00 p.m. snack. During an interview on 12/04/14, at 10:10 a.m., the director of nursing (DON) stated residents are asked their preferences during the nursing admission assessment and if the resident is unable to verbalize, they call the family. The DON stated they are asked type of bath, time of day, details about fears, etc. and will adjust their bath schedule accordingly. The DON stated residents have an opportunity to express their preferences in care conferences also, but verified the frequency of bathing was not on the care conference list of items to address with the resident or family, but planned to add it to the care conference list now. The DON stated bedtime is asked on admission and the nurses will ask residents when they want to go to bed after they have snacks. The facility policy and procedure on Resident Rights-Self Determination and Participation revised 3/08, directed staff to give residents choices and adhere to the choices if reasonable and practical to do so. The residents and their representatives are invited to patient care conferences and are encouraged to voice any choices or preferences. It further indicated residents have the right to choose activities, schedules and health care. During an interview on 12/02/14, at 8:53 a.m. R23 was interviewed and stated he received one shower weekly, but would prefer a shower more often. R23's annual Minimum Data Set (MDS) dated	F 242	ADDITIONS RELATED TO REJECTED POC: R23 was immediately interviewed on 12/5/14 by the D.O.N based on surveyor findings and stated that he did not want more frequent showers at this time, that he stated only the frequency that he had at home during his working years. Will review with resident his preferences during his quarterly care conferences. REsidnet was encouraged to notify nursing if he changes his mind. R18 was immediately interviewed on 12/5/14 by the D.O.N with her spouse present whom is here with resident each day. It was explained that the D.O.N was made aware by the state surveyor that she indicated she was kept up later then what her preference was for bedtime. She stated, "they put me to bed on most nights when I ask, but once in a while I stay up later". It was explained to please express her preference to the staff daily if she so chooses to go to bed sooner. Staff were interviewed as well and they all indicated that resident is generally the first one to bed after HS snack as per her request. The charge nurse will monitor for this on each afternoon shift to insure resident is asked. D.O.N. will provide ongoing monitoring through chart review and resident interview audits as per the QAPI plan which was immediately put into effect. Chart review will also consist of review of	

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F 242	Continued From page 15 10/02/14, indicated R23 was cognitively intact, and required physical assistance of one staff for bathing, and extensive assist of one staff for transferring, dressing and personal hygiene. R23's care plan dated 10/10/14, directed staff to assist with bathing. R23's care plan lacked resident preferences for bathing. R27's bathing schedule dated 9/22/14, indicated R23's shower was one time a week, on Friday a.m. During an interview on 12/02/14, at 9:52 a.m. R18 stated she goes to bed at 10:30 p.m. but would prefer to go to bed at 8:00 p.m. R18's annual MDS dated 11/11/14, indicated R18 was cognitively intact, and required extensive assistance of two staff for bed mobility, transfers, dressing, and personal hygiene. R18's care plan dated 11/17/14, lacked resident preferences addressing bed time. On 12/04/14, at 9:10 a.m. RN-B stated preferences are discussed at care conference if a resident has a complaint. RN-B also stated there is no specific assessment tool used to identify resident preferences regarding bathing frequency or bed time. On 12/03/14, at 9:38 a.m. RN-A stated nursing should determine resident preference regarding bathing frequency and choice of bed time.	F 242	the Quarterly care conference summary sheet to insure the preference questions are asked and followed as any changes occur. New admissions (New admission nursing assessment and bath schedules) will be reviewed through chart audits in the QAPI as well by the D.O.N. to insure the preference questions are asked, answered and care planned appropriately to insure compliance overall with resident preferences regarding bathing/showering and bed time routines are followed.	
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is	F 247		12/8/14

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F 247	Continued From page 16 changed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide prior notice of a new roommate for 1 of 1 resident (R18) reviewed for admission, transfer, discharge. Findings include: The annual Minimum Data Set (MDS) dated 11/14/14, indicated R18 was cognitively intact. On 12/2/14, at 10:02 a.m. R18 stated she was not notified before a new roommate moved into her shared room. On 12/3/14, at 11:45 a.m. during an interview with R18 and her representative, both stated the facility did not inform either one of them prior to the arrival of the new roommate (R11). R18 stated, "One day she just showed up." The medical records lacked evidence R18 was provided advance notice prior to the change. On 12/3/14, at 1:00 p.m. the director of nursing (DON) stated historically they do not record when a resident is informed prior to getting a new roommate. "We just tell them or their loved ones verbally." The facility's Resident Rights-Change in Room or Roommate policy revised on 2/08 indicated the resident had the right and would be informed when there is a change in room or roommate.	F 247	F0247: It is the policy of the Cook Hospital as indicated in the policy "Resident Rights-change in room or roommate" to notify a resident of change in room or roommate. This policy has now been updated to also indicate that this notification to resident of a new roommate will be noted in the nurses notes when the notification has been made. R18 Stated to state surveyors that she was not notified of a new roommate. In the future the expectation with the new policy is that the licensed nurse must document in the residents EMR when the notification is made of a new roommate. All nursing staff were immediately re-educated, new nursing staff will be educated through their checklist during their orientation period of the change in roommate policy stated above. This is placed as a QAPI for the D.O.N to perform ongoing compliance and monitoring for notification. ADDITIONAL INFORMATION REQUESTED: QAPI which is in place will monitor compliance with roommate notification through chart review of nurses notes in	

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F 247	Continued From page 17	F 247	which the charge nurse will document the notification to the resident of an upcoming roommate as well as audits with residents throughout the next few quarters.	
F 252 SS=C	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident furniture in the common area was maintained in a homelike manner. This deficient practice had the potential to affect all 23 residents in the facility. Findings include: During the initial tour on 12/1/14, at 2:07 p.m. the chairs in the resident lobby, which were prominently visible to all residents and visitors were noted to be covered with large cloth-style incontinent soaker pads. Observation on 12/02/14, at 8:09 a.m. revealed the cloth incontinent pads were still present on the resident recliner chairs and glider rockers in the lobby. During interview on 12/03/14, at 11:23 a.m., R17 stated she did not feel the incontinent pads looked very nice and that they bothered her. She	F 252	F0252: It is the policy of the Cook Hospital and Nursing Home to provide a clean, comfortable and homelike environment, allowing residents to use his/her personal belongings to the extent possible. White incontinence cloth pads were removed from the recliner chairs in the common dayroom immediately on 12/4/14 and staff were educated that only those residents whose families had requested cloth incontinence pads be placed on their recliner chairs due to the inability to wash thoroughly if an incontinence accident should occur would be allowed to have incontinence cloth pads when the resident is seated in the recliner only. New cloth pads were ordered specifically for these residents that have the appearance of a flannel blanket creating a	12/30/14

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F 252	Continued From page 18 indicated they were always present on the chairs, and thought they were for "softness. R17's annual minimum data set (MDS) revealed a Brief Interview for Mental Status (BIMS) score of 13 (cognitively intact). During interview on 12/03/14, at 11:18 a.m., R23 indicated the pads were on the chairs in case the resident's were incontinent of urine and had an "accident." He indicated the pads were always on the chairs. R23's annual MDS, dated 10/2/14 revaled a BIMS score of 10 (moderate cognitive impairment). During interview on 12/03/14, at 11:28 a.m., family (F)-A stated the pads were always on the chairs because some of the people had bladder control problems. F-A indicated the pads being on the chairs could imply to the public that residents were incontinent of bladder, and did not feel they were homelike. During itnerview on 12/04/14, at 8:53 a.m. R25 indicated the incontinent pads were on the chairs for people who wet themselves. R25 stated she did not like the appearance of the pads but "supposed it was safer for accidents." R25's annual MDS revealed a BIMS score of 15 (cognitively intact). During interview on 12/03/14, at 11:38 a.m. nursing assistant (NA)-A stated the pads were not homelike and did not appear dignified. NA-A stated staff could "keep up on residents' toileting programs to prevent incontinence instead. NA-A stated the incontinent pads had always been on the chairs since she began working at the facility. During interview on 12/04/14, at 10:06 a.m.,	F 252	more "homelike environment". These cloth pads are to be utilized only when the resident is placed in the chair as per family request. This is included in the comprehensive care plan for each individual resident. ADDITIONAL INFORMATIN RELATED TO REJECTED POC: Charge nurse and D.O.N will monitor this plan on a daily basis to insure incontinence soaker pads are not placed on all recliner chairs without indication for use as will be clearly outlined in the residents comprehensive care plan. QAPI was immediately created by the D.O.N to provide ongoing monitoring of this plan.	

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F 252	Continued From page 19 registered nurse (RN)-A stated the facility did not have any residents that were inappropriately voiding on furniture at this time, and the facility was trying to improve the continence level for all residents. RN-A could not think of any residents that had incontinence which was not well-managed at the present time, and did not feel the pads were necessary on the chairs. RN-A stated that she had worked at the facility ten years ago and the pads were on the chairs then. RN-A felt placing the pads on the chairs was something being done more out of staff habit than to meet resident needs, and should not be continued. The facility policy entitled Resident's Bedroom Accommodations, last revised 4/06, revealed the facility must provide for a safe, clean, comfortable and homelike environment.	F 252		
F 329 SS=D	. 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329		12/30/14

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F 329	Continued From page 20 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a comprehensive care plan was developed for monitoring of psychotropic medications for 1 of 5 residents (R27) reviewed for unnecessary medications. Findings include: The diagnosis summary list in the electronic medical record indicated R27 had diagnoses of depression and anxiety. The quarterly minimum data set (MDS) dated 9/4/14, indicated R27 was cognitively intact, had no behaviors during the assessment period, and had minimal mood indicators. The MDS also indicated R27 had a diagnosis of depression. The admission care area assessment (CAA) for psychotropic drug use dated 6/9/14, indicated	F 329	F329: It is the policy as indicated in the policies : Psychotropic Medications and Psychotropic Drug Use- Accepted Indications that residents receiving psychotropic medications will be monitored closely for side effects, appropriate indications for use, correct diagnoses, ongoing correct use of medication as a PRN, as well as the proper reductions will be attempted. These medications will only be utilized when all other non-pharmacological interventions have failed. The policies noted above were revised to indicate specific monitoring by the MDS/PPS nurse, review at the quarterly care conferences, as well as with any condition changes. Any resident with an	

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F 329	Continued From page 21 R27 had no adverse effects to the antidepressant at that time. The CAA indicated nursing was to administer medications as ordered and monitor for side effects and effectiveness of medication. The signed physician orders dated 11/11/14, indicated R27 had orders for Clonazepam (for anxiety) 0.25 milligrams (mg) by mouth three times daily for agitation, Ativan (for anxiety) 0.5 mg by mouth every 6 hours as needed (PRN) for agitation, and Remeron (for depression) 7.5 mg by mouth daily at bedtime. R27's care plan does not address the monitoring psychotropic medications for side effects, appropriate indications for use, or resident's diagnoses of depression and anxiety. The November PRN medication Flow Sheet indicated R27 had received Ativan eight times for anxiety. Twice the indication indicated R27 was crying. The documentation lacked signs and symptoms of R27's anxiety. R27 did receive relief from the Ativan when it was given. During an observation on 12/3/14, at approximately 11:50 a.m. R27 was tapping her foot while sitting at the table in the day room. After using the bathroom, she indicated she had pain and when brought to her room, she became short of breath and had a distressed facial expression. R27 indicated she wanted the nurse. The registered nurse (RN)-C went to the resident's room and administered Ativan for resident's anxiety. During an interview on 12/03/2014, 12:00 p.m. registered nurse (RN)-C verified the indication for Ativan is agitation. RN-C stated R27 will request	F 329	antipsychotic medication will receive the appropriate consent form and trial reductions. All of the indications for use, side effects, ongoing monitoring efforts will be noted on the residents comprehensive care plan. R27 was reviewed for her usage of psychotropic medications. The comprehensive care plan has been updated to reflect the necessary and required indications, side effects, monitoring and reduction trials along with nonpharmacological interventions that staff must attempt before administering on a PRN basis. All nursing staff were immediately re-educated to this as well as the MDS nurse. The physicians will be re-educated at the med staff meeting in January, 2015 to insure the plan of care and assessments for use of psychotropic medications is completed frequently to assure the medication continues to be necessary. Pharmacy was also updated with the pharmacist continuing to make her recommendations monthly through her pharmacy QA review forms. QAPI is initiated by the D.O.N to insure compliance with the above plan. ADDITIONAL INFORMATION RELATED TO REJECTED POC: As noted above in the POC "specific monitoring by the MDS/PPS nurse, review at the quarterly care conferences, as well	

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F 329	Continued From page 22 it to help her relax. RN-C stated when R27 becomes anxious, she starts to tap her foot, etc, but sometimes is able to calm down. RN-C stated R27 is able to request medications, and will sometimes ask for it when she is anxious and can't sleep. During an interview on 12/04/14 at 10:24 a.m. the DON verified R27's care plan does not address psychotropic medications. The facility policy and procedure for psychotropic medication revised 9/10, lacks direction for care planning and monitoring of psychotropic medications.	F 329	as with any condition changes". "All of the indications for use, side effects, ongoing monitoring efforts will be noted on the residents comprehensive care plan"."The physicians will be re-educated at their medical staff meeting 1/15 to insure the plan of care and assessments for use of psychotropic medications is completed frequently to assure the medication continues to be necessary." Pharmacy will also continue to make recommendations for use of medication during their monthly review of all medication. In addition a QAPI plan was immediately initiated by the D.O.N to insure medications are reviewed monthly by pharmacy, quarterly in care conferences by the MDS/PPS nurse and with condition changes by the MDS/PPS nurse as well as quarterly by physicians during rounds (with documentation of all noted on appropriate forms in the EMR. This will be performed per the D.O.N by review/audit of pharmacy QA therapeutic recommendations monthly, review of physicians rounds quarterly, and at quarterly care conferences by reviewing and auditing the charts of residents for specific medications and appropriate documentation exists for the need to continue (with appropriate diagnoses) or perform reduction trial with results of such indicated in the resident record as well.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371		12/8/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING _____ B. WING _____	12/04/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 23 (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure reusable ice packs used for physical therapy treatments were stored away from resident's personal food in 1 of 1 resident refrigerators/freezers on the nursing unit. This had the potential to effect all residents in the facility. Findings include: On 12/01/14, at approximately 5:00 p.m. the resident's refrigerator/freezer on the nursing unit was observed to contain four cartons of ice cream, one container of frozen whipped topping, one pumpkin pie, and two reusable ice packs. On 2/01/14, at 5:36 p.m. licensed practical nurse (LPN)-A verified the physical therapy ice packs were in the freezer, stored with resident food items. On 12/01/14 7:03 p.m. the director of nursing (DON) verified the physical therapy ice packs were in the freezer, and did not belong with resident's food. On 12/04/14 8:50 a.m. the dietary manager (DM)	F 371	F0371:It is the policy of the cook hospital and nursing home to insure food is stored in a safe manner. The following policy was created to insure staff are trained, audited and evaluated in regards to safe food storage in the NH kitchenetter refrigerator/freezer. The policy is titled, "Food storage in kitchenette refrigerator- NH". All staff were re-educated immediately on this policy. A sign was immediately placed on the refrigerator that indicates only food products may be stored in the refrigerator. QAPI is set up by the D.O.N to monitor the overall compliance with food storage in the refrigerator / freezer. The charge nurse on each shift will inspect the refrigerator/freezer to insure that only food products are placed within it. Added r/t rejected POC:	

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F 371	Continued From page 24 stated she was not aware of the physical therapy ice packs in the resident's unit refrigerator/freezer, but the ice packs should not be stored with resident food. The facility was unable to provide a policy and procedure on food storage and reusable resident ice packs.	F 371	The ice pack which was noted by the MDH surveyor was removed immediately by the D.O.N when MDS surveyor alerted the D.O.N. All food in the freezer was immediately removed as well, dietary cleansed freezer per protocol. Therapy does not apply the ice packs in the nursing home, nursing staff applies and were made aware through immediately education of food storage policy in the kitchenette refrigerator/freezer. See Plan outlined above to insure proper storage of only food items in refrigerator/freezer in the future.	

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	245392	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/04/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on June 3, 2014. At the time of this survey Cook Hospital C & NC was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 St. Paul, MN 55101- 5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/22/2014

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

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K 000	Continued From page 1 By email to: Marian.whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Cook Hospital C & NC is a 1-story building with a partial basement. The original building was constructed in 1960 with additions in 1966, 2000, and 2005 The original building buildings and additions are all Type II (111) construction, therefore, the facility was inspected as one building. The facility has a clinic, hospital and an administrative wing that are properly separated from the nursing home. The building is fully fire sprinkler protected.. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 28 beds and had a census of 26 at the time of the survey.	K 000		

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K 000	Continued From page 2	K 000		
K 061 SS=F	The standard is NOT met as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: Based on observation two water supply control valves on the complete automatic fire sprinkler system are not secured in the open position as required by MSFC(07) section 903.4.4. This deficient practice could effect all of the occupants of the building in the event of a fire. Findings include: At the conclusion of the building tour on 12-4-14 at 10:00AM, while I was exiting the facility, it was observed that two valves that control the water supply to the complete automatic fire sprinkler system were not secured in the open position. They are located in the main stairwell to the basement (at the top) and in the corridor of the basement that the stairwell opens into.	K 061	K0061: It is the policy of the of the Cook Hospital and Nursing Home to insure that the required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. The Valves were immediately secured in the open position in compliance with NFP 101 Safety Code. Fire Sprinkler Maintenance and testing policy was developed which includes a inspection checklist which will be performed quarterly, semi-annual and every 5 years to meet safety code. Maintenance staff were educated immediately as to the new policy, and inspection checklist. (see attached policy and checklist)	12/22/14
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance	K 147		1/8/15

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K 147	Continued From page 3 with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, multi-plug power strips were found to be in use. This deficient practice could affect all occupants. Findings include: During the facility tour on 12-4-14 between 8:00-10:00AM, it was observed that non approved multi-plug power strip were in use in several areas of the facility. They were observed in resident rooms and common spaces. Non approved power strips do not meet the requirements of NFPA 70. This deficient practice was confirmed by the Maintenance Supervisor (MT) at the time of exit.	K 147	F0147: It is the policy of the cook hospital and nursing home to insure that all electrical wiring and equipment is in accordance with NFPA 70. All multi-power strips have been replaced with UL rated 60601-1 Hospital grade patient care area multi power strips. A Power Strips and Extension Cords policy was developed which includes the NFPA70 and NFPA99 regulations. Maintenance staff have been educated related to the policy. Cook Hospital and Nursing Home will document compliance with CMS Categorical Waiver ref: S&C: 14-46-LSC All staff will be educated immediately to monitor for improper or questionable power strips. If questioning power strip compliance they will immediately notify the maintenance supervisor for evaluation.	