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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: H0RJ

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245412**
2.STATE VENDOR OR MEDICAID NO.
(L2) **961043000**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/05/2012** (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 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Post Certification Revisit to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B for both health and Life Safety Code. Effective March 27, 2012, the facility is certified for 56 skilled nursing facility beds.

17. SURVEYOR SIGNATURE — Date :
Brenda Fisher, Unit Supervisor — 04/17/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Colleen B. Leach, Program Specialist — 04/17/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Uploaded 4/23/2012 DB

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/16/2012
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5412 April 17, 2012

Ms. Nancy Stratman, Administrator
Cokato Manor
182 Sunset Avenue
Cokato, Minnesota 55321

Dear Ms. Stratman:

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 March 27, 2012, the above facility is certified for:

56 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900 , St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 17, 2012

Ms. Nancy Stratman, Administrator
Cokato Manor
182 Sunset Avenue
Cokato, Minnesota 55321

RE: Project Number S5412022

Dear Ms. Stratman:

On March 5, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 16, 2012. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 5, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 26, 2012 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 16, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 27, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 16, 2012, effective March 27, 2012 and therefore remedies outlined in our letter to you dated March 5, 2012, 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.

Sincerely,

Brenda Fischer

Brenda Fischer, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320)223-7338 Fax: (320)223-7348

Enclosure

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
245412	A. Building B. Wing	4/5/2012

Name of Facility	Street Address, City, State, Zip Code
COKATO MANOR	182 SUNSET AVENUE COKATO, MN 55321

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **03/27/2012**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **03/27/2012**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **03/27/2012**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/27/2012**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **03/27/2012**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/27/2012**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/cbl	04/17/2012	10562	04/05/2012
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/16/2012			

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
245412	A. Building / B. Wing: **01 - MAIN BUILDING 01**	3/26/2012

Name of Facility	Street Address, City, State, Zip Code
COKATO MANOR	182 SUNSET AVENUE COKATO, MN 55321

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0050	**03/14/2012**	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		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** PS/cbl	**Date:** 04/17/2012	**Signature of Surveyor:** 27200	**Date:** 03/26/2012
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 2/14/2012		**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: H0RJ

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245412**
2.STATE VENDOR OR MEDICAID NO.
(L2) **961043000**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/16/2012** (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 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. Please refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post certification Revisit to follow.

17. SURVEYOR SIGNATURE — Date :
Michelle Thompson, HFE NE II — 04/02/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Colleen B. Leach, Program Specialist 04/13/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Uploaded 04/16/12 DB H0RJ

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

Certified Mail # 7010 2780 0001 4939 6957

March 5, 2012

Ms. Nancy Stratman, Administrator
Cokato Manor
182 Sunset Avenue
Cokato, Minnesota 55321

RE: Project Number S5412022

Dear Ms. Stratman:

On February 16, 2012, 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;

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 27, 2012, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 27, 2012 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that

substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 16, 2012 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 16, 2012 (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:

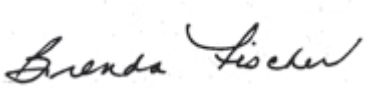
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Brenda Fischer, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320)223-7338 Fax: (320)223-7348

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245412	A. BUILDING _____ B. WING _____	02/16/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 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 State survey and certification agency). The facility must have evidence that all alleged	F 225	4/3/12 POC accepted.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Stratman — TITLE: Administrator — (X6) DATE: 3-21-2012

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245412	A. BUILDING _____ B. WING _____	02/16/2012

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

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F 225	Continued From page 1 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 record review the facility failed to ensure that all alleged abuse, neglect and injuries of unknown origin were thoroughly investigated or reported to the state agency immediately for 2 of 5 residents (R50, R49) reviewed for alleged abuse, neglect and injuries of unknown origin. Findings include: R50 had multiple bruises of unknown origin that was not thoroughly investigated and reported to the state agency immediately. R50 had diagnoses that included memory loss. The quarterly Minimum Data Set (MDS) dated 11/16/11 indicated that R50 was cognitively impaired. Review of the facility Injury report dated 1/09/12 no time identified, only "am", indicated R50 had a 1.5 centimeter (cm) by 1 cm skin tear to her right index finger. The report also identified the	F 225		

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F 225	Continued From page 2 following multiple bruises: Right bicep 3cm in diameter purple/yellow, Right elbow 1 cm purple, 0.5cm purple, Right forearm 4cm by 4cm pink 1 cm purple, 0.7cm purple, 1cm red Right wrist 4cm by 3cm, 1.22 x 1.7cm dark purple Right hand 4cm by 3 cm dark purple, 0.7cm by 0.4cm red and 1.3cm by 0.8 cm red Left bicep 1.2cm by 1cm red, 4cm by 1 cm red purple Left shoulder 0.4cm by 0.3cm, 0.5cm by 1cm, 0.3cm by 0.8cm all red The report also identified R50 received aspirin 325mg (analgesic, anti-coagulant) which was a contributing factor to the injuries. The report indicated that R50 doesn't know what had happened and does not know the cause. The injury report indicated these injuries were related to R50 "resistive behavior". A questionnaire was completed by five staff members, four of the staff members indicated they did not know when the bruises occurred. Nursing assistant (NA)-A indicated that on 1/9/12 at 4:00 am he and another staff member went into R50's room to change her "we pulled her blankets down and proceeded to change her. She was getting upset and hitting and scratching staff. We explained to her it hurt and to please stop so we can finish. We reassured we were changing her so her bottom doesn't get sore. (I did not see and bruises or scratches) once we started cares on her she became upset and hitting, scratching and pinching". NA-A then stated her scratches may been from her scratching herself and that her nails are really sharp. The investigation lacked any environmental factors for a potential cause, nor did the facility observe R50 cares to	F 225		

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F 225	Continued From page 3 determine if these injuries could potentially be a result of the care R50 received. The administrator was informed of the injuries, but there was no indication the state agency had been notified of the incident. At 9:00 a.m. on 2/15/12 the Director of Nursing (DON) stated "she felt the bruising the R50 had was from her being combative with cares." The DON verified the investigation was not thorough and they had not reported the incident to the state agency. Although the facility was aware of the multiple bruises and a skin tear R50 received, the facility lacked a thorough investigation of these injures nor was the state agency notified of the incident even though R50 had multiple injuries which were not explained. R49 had a abuse allegation that was not immediately reported to the state agency. Review of R49's Incident report submission to the state agency indicated that on 11/01/11 at 3:34p.m., R49 reported a staff member was rough during a transfer. The report was submitted to the state agency on 11/2/11 at 4:16p.m. the following day. The facility completed and submitted an investigation on 11/3/11 which indicated "Interviews were conducted with the reporter, charge nurse and resident who had recently expressed concern with the same staff member. Perpetrator was immediately dismissed from the building when report was made by the reporter. ..and was released from employment on 11/4/11.	F 225		

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F 225	Continued From page 4 Although the facility was aware of the incident that occurred on 11/1/11 at 3:34p.m., the facility did not notify the state agency immediately and contacted them the following day 11/2/11 at 4:16p.m. At 9:00 a.m. on 2/15/12 the DON verified the facility did not report the incident to the state agency immediately.	F 225		
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 develop and implement an abuse prohibition policy which required a thorough investigation of any alleged abuse, neglect, injuries of unknown origin and immediate notification to the state agency for 2 of 5 residents, (R50, R49) with alleged allegation of abuse, neglect and injuries of unknown origin. Furthermore, the facility failed to check with the nurse licensing boards to ensure 2 of 2 nurses reviewed had a current licensure without any restrictions which had the potential to effect 55 residents who currently resided in the facility. Findings include: The facility policy "Check list for Reporting Vulnerable Adult" revised Dec. 2011 indicated	F 226		

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F 226	Continued From page 5 "there is a requirement to report online to OHFC (Office Of Health Facility Complaints) immediately, which means as soon as possible but in no case no more than 24 hours. The policy also indicated the nurse to "document the incident/injury/fall on the appropriate form and begin investigation utilizing one or more of the following : staff interview, resident interviews, review of 24-hour board, etc." R50 had multiple bruises of unknown origin that was not thoroughly investigated and reported to the state agency immediately as identified by the facility policy. R50 had diagnoses that included memory loss. The quarterly Minimum Data Set (MDS) dated 11/16/11 indicated that R50 was cognitively impaired. Review of the facility Injury report dated 1/09/12 no time identified, only "am", indicated R50 had a 1.5 centimeter (cm) by 1 cm skin tear to her right index finger. The report also identified the following multiple bruises ranging from .5cm to 4 cm on her right wrist, elbow, forearm and bi-cep. The report also identified some bruising that ranged from .3cm to 4cm on her left shoulder, and bi-cep. The report indicated that aspirin 325 mg (analgesic, anti-coagulant) was a contributing factor along with R50's "resistive behavior." A questionnaire was completed by five staff members, four of the staff members indicated they did not know who with bruises happened. Nursing assistant (NA)-A indicated that on 1/9/12	F 226		

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F 226	Continued From page 6 at 4:00 am he and another staff member went into R50's room to change her and R50 was "hitting and scratching staff." NA-A then stated R50's scratches may have been from R50 scratching herself and her nails were really sharp. A thorough investigation was not completed to determine potential environmental factors, or if R50 potentially received these injuries when cares were provided. The administrator was notified of the incident, but there was no indication the state agency was immediately notified. At 9:00 a.m. on 2/15/12 the Director of Nursing (DON) stated verified the report lacked a thorough investigation and the incident had not been reported to the state agency . Although the facility was aware of the multiple injuries, in which they were unable to explain, the facility did not completed a thorough investigation of the incident according to the facility policy nor was the state agency notified of the incident immediately according to the policy. R49 had a abuse allegation that was not immediately reported to the state agency according to the facility policy. Review of R49's Incident report submission to the state agency indicated that on 11/01/11 at 3:34p.m., R49 reported a staff member was rough during a transfer. The report was submitted to the state agency on 11/2/11 at 4:16p.m. the following day. The facility completed and submitted an investigation on 11/3/11 which	F 226		

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F 226	Continued From page 7 indicated "Interviews were conducted with the reporter, charge nurse and resident who had recently expressed concern with the same staff member. Perpetrator was immediately dismissed from the building when report was made by the reporter. ..and was released from employment on 11/4/11. The administrator was notified of the incident. Although the facility was aware of the incident that occurred on 11/1/11 at 3:34p.m., the facility did not notify the state agency until the following day at 4:16p.m. the facility failed to follow there policy on reporting immediately. At 9:00 a.m. on 2/15/12 the DON verified the facility did not report to the state agency immediately. Review of 2 of 2 newly hired nurses files lacked evidence that their licensure was verified with the licensing board to ensure the license was current without any restrictions as directed by the facility policy. The facility policy "Check list for Reporting Vulnerable Adult" revised Dec. 2011 indicated, "potential employees will be screened for a history of abuse, neglect or mistreating residents. This includes attempting to obtain information form previous employers and/or current employer and validating credentials with the appropriate licensing boards and registries." Review of Registered Nurse (RN)-C employee record indicated she was hired 10/19/11. There was no indication that her license was verified with the board of nursing to ensure the license	F 226		

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F 226	Continued From page 8 was current without any restrictions. Licensed Practical Nurse (LPN)-C was hired 11/09/11 in review of her employee file there was no licensure verification with the board of nursing to ensure her license was current without any restrictions. At 8:15a.m on 2/16/12 interview with the director of nurses (DON) verified she does not check with the board of nursing for licensure verification and any restrictions. She just makes sure she has a copy of their license in the employee file. The DON stated that she did check these nurses licenses when she was made aware of the concern, and verified RN-C and LPN-C both had valid licenses without any restrictions.	F 226		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents maintained an appropriate nutritional parameters	F 325		

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F 325	Continued From page 9 to prevent further weight loss for 1 of 3 residents (R26), with a weight loss. Findings include: R26 had a 9.15% weight loss from August 2011 to February 2012 (6 months) without evidence that an ongoing assessment was completed for this weight loss. R26 had diagnoses of anxiety, depression and anemia. The current quarterly Minimum Data Set (MDS) dated 12/29/11 indicated that R26 was 67 inches tall (5ft 6 inches) weight was 135 lbs. The MDS also indicated she was alert and oriented, independent with eating, had a poor appetite and had been feeling down. During observation at 12:49pm on 2/15/12 R26 was sitting at the dinning room table, she had not eaten anything on her plate. R26 stated "I am just not hungry I have no appetite." Review of the record indicated that R26 weighed 140.5 pounds in October 2011, 140 pounds in November 2011, 135 pounds in December 2011, 128 pounds in January 2012 and 128.5 pounds in February 2012. The Nutritional assessment form dated 12/28/11 indicated R26 was on a regular diet had no interest in eating, complained of not being hungry, and her weight was down 8 pounds in last 6 months. Although the dietary manager was aware of the weight loss there was no interventions added at that time. The current plan of care dated 12/29/11 indicated "recent decline in appetite and desire to eat. 2/11 wt. 148#, 7/11 wt. 142#, 12/11 wt 135#". The	F 325		

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F 325	Continued From page 10 care plan approaches listed were "honor preferences for smaller portions, meds as ordered, monitor intakes initially and encourage and assist PRN [as needed] check quarterly, monthly weights offer waffles, pancakes or eggs if not eating a meal or does not want a scheduled meal, regular diet as ordered. cut up meats, set-u & assist at table at all meals with condiments, packets etc. asking her what she would like." Review of the medication administration records indicated that on 1/17/12 R26 was started on House supplement 4 ounces twice a day in between meals to increase calorie intake. The staff were signing they were giving the supplements but they did not indicate the amount R26 consumed. At 1:20 p.m.. on 2/15/12, interview with the dietary manager stated R26 was not eating and had no appetite. The dietary manager (DM) also stated she had started her on house supplements in January 2012 and if R26 doesn't eat a meal they offer her pancakes or eggs. DM stated they only document her intake at meals quarterly when her assessment was due and did not monitor the amount of supplement R26 was drinking and thought R26 drank 100% of the supplement. The dietary manager also stated that R26 ate better after she was Remeron (antidepressant medication that stimulates appetite) and when this medication was discontinued R26 became losing weight. Review of R26 physician orders indicated that on 1/05/09 the physician had discontinued her Remeron due to the potential side effect of bone marrow suppression. No further information was	F 325		

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F 325	Continued From page 11 provided in the medical record. Review of psychology progress note dated 12/29/11 indicated R26 "she has no appetite and would like to have an appetite because she has enjoyed food in the past"... The progress note also indicated under impression/treatment plan/recommendations: "she was most likely benefiting from the Remeron form the standpoint of stimulating her appetite. She would like her appetite back and agreed that if a medication was necessary, she would like to take it." There was no indication the physician was informed of the psychologist recommendations to help increase R26 appetite. During interview at 10:00 a.m. on 2/15/12, Licensed Practical Nurse (LPN)-A stated that on Monday she was planning to discuss with the physician the possibility of starting an appetite stimulating medication again but had not discussed this with R26 physician. During interview at 1:30p.m. on 2/16/12 R26 stated " I haven't been eating. I just don't feel like it and I have no appetite. She then stated she might like to get ice cream, but she would really like to have a milk shake right before bed" and when lost weight in the past they gave this to her and was unsure why this had stopped. R26 stated she would be willing to drink more of the supplements if they were offered and wished they would give her barbeque beef more often. Although the facility was aware that R26 had a 9% weight loss and the psychologist recommended a appetite stimulating medication the facility failed to comprehensively assess R26 weight loss to determine an appropriate plan to	F 325		

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F 325	Continued From page 12 prevent further weight loss.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not 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: Basesd on interview and document review the facility failed to adequately identify, assess, and monitor clinical indications for continued use of medications for 2 of 10 residents (R4, R56) in the sample who were reviewed for unnecessary medications.	F 329		

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F 329	Continued From page 13 Findings include: R4 received Depakene (an anticonvulsant medication) for behavioral disturbances without clear indications of what specific behaviors this medications was used for, nor what nonpharmocological interventions were implemented and if they were effective. R4's diagnoses included dementia with behavioral disturbances. The annual minimum data set (MDS) dated 11/22/11 indicated she was rarely understood but had no memory deficits, she had verbal behaviors 1-3 days and refused cares 4-6 days during the assessment period. R4's physician orders dated 2/1/12 included an order for "depakene (valporic acid) syrup; 250 mg/5 ml (250 milligrams per 5 milliliters); 10 ml; oral PO (by mouth) twice a day. No diagnosis was listed for this medication on the order sheet. At 10:50 a.m. on 2/15/12 registered nurse (RN)-B stated the depakene R4 did not have a seizure disorder, and the medication was used for R4's dementia with some behavior disturbances of resisting cares and striking out. R4's plan of care dated 1/12/12 included "behavioral symptoms, mood state, psychosocial well being (resident name) is a wandering risk and unaware of safety needs. (Resident name) has a diagnosis of dementia with behavioral disturbances, displays s/sx (signs and symptoms) of fear, apprehension, discomfort, crying, restlessness, frequent position changes." The goal was listed as "(resident name) will not leave..	F 329		

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F 329	Continued From page 14 will be free from injury accidents while wandering...will have fewer than 6 episodes per week." The plan of care did not address utilizing the anticonvulsant medication for behavioral issues, and what nonpharmocological interventions were to be implemented for these specific behaviors. R4's "consultant pharmacists medication regimen review report" dated 11/9/11 included "depakote 500 mg BID dx (diagnosis) dementia with behavioral disturbances." There is no monitoring of behaviors in the MAR. Please identify behaviors and begin monitoring." Target behavior sheets for R4 for November 10, 2011 through February 2012 had a "target behavior" listed as "striking out during cares." This behavior was displayed by R4 almost daily throughout this period, but there was no indication of what was implemented and if these interventions were effective. At 9:44 a.m. on 12/16/12 RN-A (MDS and care planning nurse) stated R4 received the depakene for dementia with behavioral disturbances. When medications are used for psychiatric disturbances we do medication monitoring in the medical record which is part of the plan of care. RN-A was unable to find any medication monitoring in the medical record or on the plan of care for R4. She stated that target behavior monitoring is in the medication administration record for behaviors R4 displayed. When reviewing the behaviors listed in R4's plan of care and the target behavior sheets, RN-A stated R4 no longer wanders as listed in her plan of care. She did not know why they were not monitoring R4 for the	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245412	A. BUILDING _____ B. WING _____	02/16/2012

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

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F 329	Continued From page 15 other listed items such as fear, apprehension, discomfort, crying, restlessness, frequent position changes. She acknowledged the plan of care failed to include "strikes out during cares" or direct staff how to care for R4 if she was striking out. Further stating the depakene wasn't being monitored as it is an anticonvulsant medication, not an antipsychotic medication and did not know if monitoring was required for this off label use of depakene. At 11:15 a.m. on 2/15/12 the facilities pharmacy consultant was interviewed via phone; she stated the facility does not need to have diagnoses listed on the physician order sheet or on the medication administration record as long as it is in the medical record some where for staff to know why the medication is being used. The physician should justify use in their notes. Physician visit summary for R4 dated 1/27/12 include she had "dementia with history of agitation. Continue current depakote" and "She has been noted to be more quiet." There was no indication of what types of behaviors R4 was receiving the depakene for. Psychology notes for R4 dated 1/12/12 included she showed signs of depression and pharmacological strategies may be of value. This would be deferred to her primary physician. "Impression/treatment plan recommendations" to staff included "continuing strategies such as complimentary therapies, heavy weighted blankets, music therapy, pet therapy, low sensory stimulus, balancing sensory stimulus with a calm environment..." There was no indication R4 received an anticonvulsant medication for	F 329		

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F 329	Continued From page 16 behavioral symptoms or her primary physician had reviewed this note. At 10:50 a.m. on 2/15/12 RN-B did not know if the suggestions made by the psychologist on 1/12/12 had been forwarded to the physician or implemented into R4's plan of care. She thought maybe they had tried weighted blankets at one time, but was not sure. The facility has pet therapy once a week, but was not sure if they visit R4. Even though R4 received depakene for "dementia with behavioral disturbances" the facility failed to identify what behaviors the medication was being used for, and if it was effective for the behaviors. Further, the facility failed to implement behavioral interventions recommended by the psychologist. R56's medication was not being appropriately monitored as directed by the Physician. R56 had diagnoses including tachycardia, shortness of breath, hypertension, atrial flutter/ fibrillation, and heart failure. The Annual MDS dated 1-12-12 identified R56 had moderate cognitive impairment and was an extensive assist with all Activities of daily living except eating. R56's current signed physician orders dated and signed by the physician on 1-26-12 identified the resident was on multiple medications which could effect the residents blood pressure including Toprol XL (antihypertensive), Zaroxolyn (diuretic/ antihypertensive), Lanoxin (antiarrhythmic), Lasix (diuretic/ antihypertensive), and Cardizem CD (hypertension). The physician orders instructed	F 329		

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F 329	Continued From page 17 staff to notify the physician if the residents systolic blood pressure (SBP) was less then 90 or greater then 200, or if the diastolic blood pressure (DBP) was less then 40 or greater then 100. The start date of this order was 11-7-11 and directed staff to do this "QAM-once a morning; 7:00 a.m." R56's Medication administration record (MAR) from November 7, 2011, December 2011, January 2012, and February 2012 were reviewed. The MAR instructed the nurses to notify the physician if R56's SBP was less then 90 or greater then 200, or if the DBP is less then 40 or greater then 100. The start date on the MAR for this order was 11-7-11. On all 4 months reviewed, the facility had been checking the residents blood pressure once a week on Friday which was the residents "bath day" and not "Q-AM" as the physician ordered on 11-7-11. During interview on 2-16-12 at 11:20 a.m. Licensed Practical Nurse (LPN)- A stated they have only been checking R56's blood pressure weekly, not daily like the physician order instructed them to. She stated, "We must have missed that." The Director of Nursing (DON) provided the original order for the daily blood pressure check for R56 dated 11-7-11 following a hospitalization for pneumonia.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428		

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F 428	Continued From page 18 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow their consulting pharmacist recommendations for 1 of 10 residents (R4) residents reviwed for unnessary medications. Furthermore the consulting pharmacist failed to identify and inform the facility there was no monitoring a medication for 1 of 10 (R56) residents reviewed for unecessary medications. Findings include: R4 received Depakene (an anticonvulsant medication), the facility had not identified behavioral reasons for this medication even though the pharmacist made a recommendation to identify and monitor R4's behavior. The facility had identified mulitple behaviors displayed by R4, however they had only implemented monitoring for striking out. R4's diagnoses included dementia with behavioral disturbances. The annual minimum data set (MDS) dated 11/22/11 indicated she was rarely understood but had no memory deficits, she had verbal behaviors 1-3 days and refused cares 4-6 days during the assessment period.	F 428		

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F 428	Continued From page 19 R4's physician orders dated 2/1/12 included an order for "depakene (valporic acid) syrup; 250 mg/5 ml (250 milligrams per 5 milliliters); 10 ml; oral PO (by mouth) twice a day. No diagnosis was listed for this medication on the order sheet. R4's "consultant pharmacists medication regimen review report" dated 11/9/11 included "depakote 500 mg BID dx (diagnosis) dementia with behavioral disturbances." There is no monitoring of behaviors in the MAR. Please identify behaviors and begin monitoring." The target behavior sheets for R4 for November 10, 2011 through February 2012 had a "target behavior" listed as "striking out during cares," but nothing else. R4's plan of care dated 1/12/12 identified "behavioral symptoms, mood state, psychosocial well being (resident name) is a wandering risk and unaware of safety needs. (Resident name) has a diagnosis of dementia with behavioral disturbances, displays s/sx (signs and symptoms) of fear, apprehension, discomfort, crying, restlessness, frequent position changes." At 9:44 a.m. on 12/16/12 RN-A (MDS and care planning nurse) reviewed the target behavior sheets and the plan of care. She identified the irregularity and stated R4 no longer wanders, and had not wandered for several months, but should be monitored for the other behaviors listed in the plan of care. They usually monitor antipsychotics for side effects and effectiveness of medication, but since R4 took an anticonvulsant medication for behaviors, this had been missed.	F 428		

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F 428	Continued From page 20 The consulting pharmacist failed to identify and report to the facility monitoring R56 blood pressure every morning as directed by the physician for R56. R56 had diagnoses including tachycardia, shortness of breath, hypertension, atrial flutter/ fibrillation, and heart failure. The Annual MDS dated 1-12-12 identified R56 had moderate cognitive impairment and was an extensive assist with all Activities of daily living except eating. R56's current signed physician orders dated and signed by the physician on 1-26-12 identified the resident was on multiple medications which could effect the residents blood pressure including Toprol XL (antihypertensive), Zaroxolyn (diuretic/ antihypertensive), Lanoxin (antiarrhythmic), Lasix (diuretic/ antihypertensive), and Cardizem CD (hypertension). The physician orders instructed staff to notify the physician if the residents systolic blood pressure (SBP) was less then 90 or greater then 200, or if the diastolic blood pressure (DBP) was less then 40 or greater then 100. The start date of this order was 11-7-11 and directed staff to do this "QAM-once a morning; 7:00 a.m." R56's Medication administration record (MAR) was reviewed from November 7, 2011, December 2011, January 2012, and February 2012. The MAR instructed the nurses to Notify the physician if R56's SBP was less then 90 or greater then 200, or if the DBP is less then 40 or greater then 100. The start date on the MAR for this order was 11-7-11. On all 4 months reviewed, the facility had been checking the residents blood pressure once a week on Friday which was the	F 428		

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F 428	Continued From page 21 residents "bath day." The Director of Nursing (DON) provided the original order for the daily blood pressure check for R56 dated 11-7-11 following a hospitalization for pneumonia. Upon review of the pharmacist "Monthly medication regimen reviews" the pharmacist reviewed R56's medications on 11-9-11, 12-14-11, 1-18-12, and 2-15-12. During all 4 visits the pharmacist did not identify any potential problems or irregularity with the residents MAR and the physician orders. During interview on 2-16-12 at 11:20 a.m. Licensed Practical Nurse (LPN)- A stated they have only been checking R56's blood pressure weekly, not daily like the physician order instructed them to. She stated, "We must have missed that." No further information was provided.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		

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F 441	Continued From page 22 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and policy review the facility failed to implement an infection control program that included ongoing surveillance of infections for the facility which could identify potential trends to prevent the spread of further infections. This practice had the potential to affect all 55 of the 55 residents currently residing in the facility. Findings include: The facilities Infection Control Program lacked	F 441		

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F 441	Continued From page 23 components related to the surveillance of resident infections. On 2-15-12 at 1:10 p.m. the facility's Infection Control Program was reviewed with the Director of Nursing (DON). The DON stated if a resident had an infection and was started on an antibiotic, that information was entered on the monthly infection control tracking sheet. The DON stated they keep track of the antibiotic, the type of infection (skin, GI, respiratory, etc), and the date. The facility tracking did not include possible type of organism, symptom of infections, patterns or clusters of infections including room location, and possible staff or environmental factors related to the organisms. The DON stated she "knows" what symptoms resident are having but does not track them anywhere and they have never tracked organisms as part of their infection control program. She also stated the infection control program is in transition right now as the infection control nurse retired several months ago. The DON stated she had not noted any trends in infections in the last year and presented a summary to the Quality assurance (QA) committee quarterly of the infections. The DON was unable to provide any summary regarding the infections because she does not write up a summary, but just reviews the information and reports to the committee if she sees any trends in infection. She further stated she had not had to do any additional staff training regarding infection control based on facility infections. Upon review of the infection control log for January 2012 it was noted the facility identified 8 respiratory infections being treated during that month. The DON stated this was not considered	F 441		

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F 441	Continued From page 24 a trend as she believed most of these individuals were on different wings. During interview on 2-20-12 at 1:45 p.m. the DON stated the facility did not have a policy related to the infection control program. She stated they are working on writing one but do not currently have one in place. No further information was provided.	F 441		

Plan of correction 2012

F225 Cokato Manor has policies and staff training in place to assure that residents, who are vulnerable adults, are protected and takes this very seriously.

Corrective action for those affected: The vulnerable adult committee reevaluated resident # 50 and #49 incident with added investigation and reporting criteria.

Identification of others having the potential to be affected: The vulnerable adult committee reviewed past incident reports.

Measures to ensure practice will not recur: Incident reporting forms have been revised to further question and investigate bruises. Based on the January 2012 regulatory call with DHS and OHFC there was reiteration and clarification of the expectation of facilities to report to the state agency in a timely manner; this learning has been incorporated into our policies and education. VA Committee members (Social Worker, DON and Administrator) will sign off incident reports.

Monitoring: The Director of Nursing will monitor each month to ensure compliance and report back to the Quality Assurance Committee until compliance is met.

Date of completion is March 27, 2012.

F226 Cokato Manor has policies and staff training in place to assure that residents, who are vulnerable adults, are protected and takes this very seriously.

Corrective action for those affected: Resident #50 investigation of bruises noted has been done and is on file. Incident involving resident #49 was reviewed under new training. Nursing licenses for all nurses were verified before the completion of this survey to assure they were current and without any restrictions.

Identification of others having the potential to be affected: VA Committee reviewed past incident reports.

Measures to ensure practice will not recur: Incident reporting forms have been revised to further question and investigate bruises. Based on the January 2012 regulatory call with DHS and OHFC there was reiteration and clarification of the expectation of facilities to report to the state agency in a timely manner; this learning has been incorporated into our policies and education. VA Committee members (Social Worker, DON and Administrator) will sign off on incident reports. Nursing licenses will be verified online at the time of hire and annually at the time of performance evaluation by the Director of Nursing.

Monitoring: A recap of incident reports will be made to the QA committee quarterly by the Director of Nurses; license verification will be done annually to the QA committee by the Director of Nurses. Monitoring will continue each month until compliance is met.

Date of Completion is March 27, 2012.

F325 Acceptable parameters for nutritional status

Corrective action for those affected: Dietary manager met with resident #26 to review food preferences and will have weight taken weekly until weight is stable. She has also has been seen by her primary physician to ensure her medical needs are met and a review of her medications.

Identification of others having the potential to be affected: Director of Nursing and Dietary manager reviewed weights for the previous six months to identify any other residents at risk for significant weight loss.

Measure to ensure practice will not recur: We reviewed and revised our nutritional policy to identify significant weight loss and measures to put in place. Residents that are identified with a significant weight loss will be discussed at our weekly interdisciplinary meeting to determine an appropriate plan to prevent further weight loss. We also have placed department managers in the dining room during the noon meal during the week to observe residents.

Monitoring: Nursing, Registered Dietician and the Dietary Manager will review weights on a monthly basis until compliance is reached and report back to the QA committee.

Date of completion is March 27, 2012.

F329 Drug regimen is free from unnecessary drugs

Spoke with the Department of Health Supervisor and verified that the resident identified in this citation was resident #57 not #4.

Corrective action for those affected: Resident #57 passed away since this survey. Resident #56 was seen by her primary care physician to review her plan of care and discontinued her daily blood pressure checks.

Identification of others having the potential to be affected: Audits of our medication administration records and physician orders were performed on all residents to identify others affected by the deficient practice.

Measures to ensure practice will not recur: The process of completing MAR's with dosage schedule along with nursing instructions for medications noting clinical indications for use was updated. A double check system is now in place where two licensed staff will review and verify accuracy prior to posting new MAR's in the beginning of each month. The staff members involved in the transcription error on resident # 56 were provided with additional information on March 16-19, 2012.

Monitoring: Health Information Services and nursing staff will audit proper transcription of MAR's on the last working day of each month or upon completion, whichever is first, to ensure two signatures of licensed staff have reviewed and verified accuracy. Health information services and Director of Nursing will audit pharmacist's monthly review to ensure completion of clinical indicators being monitored. The Director of Nursing will monitor monthly and report back to the Quality Assurance Committee until compliance is met.

Date of completion is March 27, 2012.

F428 pharmacist review

Corrective action for those affected: Resident # 57 passed away since survey. Resident #56 was seen by her primary physician to review her plan of care and discontinued her daily blood pressure checks. Our consulting pharmacist reviewed her medication regimen on 3-22-2012.

Identification of others having the potential to be affected: Audits of our medication records and physician orders were performed on all residents.

Measure to ensure practice will not recur: The process of completing MAR's with dosage schedule along with nursing instructions for medications noting clinical indications for use was updated. A double check system is now in place where two licensed staff will review and verify accuracy prior to posting new MAR's in the beginning of each month.

Monitoring: Health information services and nursing staff will audit proper transcription of MAR's on the last day of each month or upon completion, whichever is first, to ensure two signatures of licensed staff have reviewed and verified accuracy. Health information services and director of nursing will audit pharmacist monthly review to ensure completion of clinical indicators being monitored. The Director of Nursing will monitor each month to ensure compliance and report back to the Quality Assurance Committee until compliance is met.

Date of completion is March 27, 2012.

F441 Infection control

Cokato Manor maintains an Infection Control Program designed to help prevent the development and transmission of disease and infection.

Corrective action for those affected: Infection logs for the previous six months were reviewed to identify any affected by the deficient practice.

Identification of others having the potential to be affected: Past infection logs were reviewed to identify any others.

Measure to ensure practice will not recur: Cokato Manor infection logs were revised to identify symptoms of disease to better track infections. We also included a section to track microorganisms of urinary tract infections and specific symptom to better track any trends in illness.

Monitoring: Director of Nursing and Infection Control nurse will monitor each month to ensure compliance and report to the Quality Assurance Committee until compliance is met.

Date of completion is March 27, 2012.

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	245412	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/14/2012

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Cokato Manor was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: PATRICK SHEEHAN, SUPERVISOR HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145 Pat.Sheehan@state.mn.us	K 000	RECEIVED MAR 19 2012 MN DEPT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION See attached RECEIVED MAR 19 2012 MN DEPT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION POC ok PS 3-20-12	

DC: 03.28.2012

EXIT: 02.16.2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Stratman | TITLE: Adm. | (X6) DATE: 3/15/12

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245412	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/14/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 *****DO NOT FAX***** THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Cokato Manor is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1964 and was determined to be of Type II(111) construction. In 1995, an addition was constructed to the east wing and was determined to be of Type II(111) construction. Another addition was added in 1999 to the south wing and was determined to be Type II (111). Because the original building and the 2 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 56 beds and had a census of 51 at time of the survey.	K 000		

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K 050 SS=F	Continued From page 2 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This Standard is not met as evidenced by: This STANDARD is not met as evidenced by: Based on review of reports, records and interview, it was determined that the facility failed to conduct the required number of fire drill in the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all residents, visitors and staff. Findings include: On facility tour between 10:30 AM and 12:30 PM on 02/14/12, during a documentation review of the available fire drill reports and interview with the Maintenance Supervisor (SS), it was revealed that the facility failed to ensuring their compliance with the one per shift per quarter fire drill requirements for Institutional/Healthcare occupancies by failing to conduct one the four required fire drill for the overnight shift during the last 12 months This deficient practice was verified by the	K 050		

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K 050	Continued From page 3 occupancies by failing to conduct one the four required fire drill for the overnight shift during the last 12 months This deficient practice was verified by the Maintenance Supervisor (SS).	K 050		

Cokato Charitable Trust

Health and Housing Services

Cokato Manor
182 Sunset Avenue NW
Cokato, MN 55321
Phone: (320) 286-2158
Fax: (320) 286-2031

Heritage Place
182 Sunset Avenue NW
Cokato, MN 55321
Phone: (320) 286-2158
Fax: (320) 286-2031

Edgewood Gables
600 Third Street SE
Cokato, MN 55321
Phone: (320) 286-2159
Fax: (320) 286-2307

Cokato Manor Home Health
600 Third Street SE
Cokato, MN 55321
Phone: (320) 286-3049
Fax: (320) 286-2307

Brookridge
180 Sunset Avenue NW
Cokato, MN 55321
Phone: (320) 286-3196
Fax: (320) 286-3163

- Sr. Day Services
- Cokato Sr. Dining
- Meals on Wheels
- Rehab Services
- Transportation

Cokato Manor
182 Sunset Ave.
Cokato, MN 55321

Provider #245412

Patrick Sheehan, Supervisor
HealthCare Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, MN 55101-5145

Mr. Sheehan:

Please accept the following as the Plan of Correction for the recent Life Safety Code Survey conducted at Cokato Manor.

Plan of Correction

K050 – A master calendar has been developed by the Environmental Services Director to ensure that a randomly scheduled fire drill is scheduled at least quarterly on each shift to assure that staff is knowledgeable in the event of a fire. This calendar will be posted in the Environmental Services Director's office and with the administrator.
Date of completion: March 14, 2012
Person responsible: Environmental Services Director will be responsible for the planning and implementation of each fire drill.

Sincerely,

Nancy Stratman

Nancy Stratman
Administrator