Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 3, 2025

Administrator
Cokato Manor
182 Sunset Avenue
Cokato, MN 55321

Re: Reinspection Results
Event ID: RKHH12

Dear Administrator:

On July 1, 2025, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 25, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 3, 2025

Administrator
Cokato Manor
182 Sunset Avenue
Cokato, MN 55321

RE: CCN: 245412
Cycle Start Date: April 25, 2025

Dear Administrator:

On July 1, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 13, 2025

Administrator
Cokato Manor
182 Sunset Avenue
Cokato, MN 55321

RE: CCN: 245412
Cycle Start Date: April 25, 2025

Dear Administrator:

On April 25, 2025, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 July 25, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by October 25, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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 _____	04/25/2025

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
E 000	Initial Comments On 4/21/25 through 4/25/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/21/25 through 4/25/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578		6/20/25

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

Electronically Signed | 05/23/2025

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

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F 578	Continued From page 1 §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the	F 578		

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F 578	Continued From page 2 appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to ensure advanced directives for emergency treatment were accurately reflected in all areas of the medical record to ensure the residents wishes would be implemented correctly in an emergent situation for 1 of 1 (R45) residents reviewed for inconsistent advanced directives. Findings include: R45's quarterly Minimum Data Set (MDS) dated 2/7/25, indicated R45 was admitted on 8/5/2024, was cognitively intact, and had the following diagnoses: Hyperlipidemia (high fat levels in the blood), and Schizophrenia. R45's untitled code status form dated 8/5/2024, indicated R45's resuscitation wishes were "Do Not Resuscitate". The Document was signed by R45, their family member, and the physician. R45's physician orders reviewed and saved on 4/21/25 at 6:01 p.m., indicated R45 was FULL CODE. On 4/21/25 at 6:02 p.m., trained medical assistant (TMA)-B stated they would refer to the resident's hard chart when the needed to know their code status. TMA-B went to charting room and visually pointed out R45's code status was DNR on their hard chart, which would have been correct. On 4/21/25 at 6:05 p.m., registered nurse (RN)-A stated when needed to confirm a resident's code status they would use the hard chart or the face	F 578	Deficiency: Facility failed to ensure advanced directives for emergency treatment were accurately reflected in all areas of the medical record to ensure the residents wishes would be implemented correctly in an emergency situation for 1 of 1 (R45) resident reviewed for inconsistent advanced directives. Tag Number: F578 _____ 1. Corrective Action Steps: The Director of Nursing immediately updated R45s health care record after the discrepancy was noted to reflect the correct code status on April 25, 2025. _____ 2. Identification of Other Residents at Risk and Action Taken: The Director of Nursing and staff RN audited all current resident charts on April 26, 2025, to ensure advanced directives were accurate in all facility records. No discrepancies found. _____ 3. Systemic Changes Implemented: The DON and Staff RN will review and audit advanced directives upon admission, quarterly and with significant change to ensure records are consistent and accurate throughout the medical record. Code status will be added to the admission check list.	

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F 578	Continued From page 3 sheet. RN-A confirmed R45 was a DNR. RN-A stated the provider would typically go over the code status with a resident and then it would be entered into the charting system. On 4/21/25 at 6:09 p.m., the director of nursing (DON) stated their expectation for checking code statuses was employees will check the resident's hard chart in the report room, where the code statuses are on the side of the book, in their medical administration record (MAR), or on the matrix banner. Typically, social services will go over code statuses with residents, and then a record keeper will enter the order once it is signed. DON stated RN's will typically review the code status order prior to it being entered into the electronic medical record (EMR) but stated it was not always happening. The DON reviewed R45's chart and EMR and stated R45 was a DNR, the DON then reviewed the physician orders and confirmed R45's was listed as a FULL CODE and not a DNR as per R45's wishes. The DON confirmed all areas in the chart should match to fulfill the resident wishes. The facility's Cardiopulmonary Resuscitation (CPR) policy last reviewed 1/2025, indicated they provided basic life support, including CPR-Cardiopulmonary Resuscitation, when a resident required such emergency care, subject to physician order and resident choice indicated in the resident's advance directives.	F 578	Code status policy reviewed and updated. _____ _____ 4. Monitoring and Quality Assurance: The Director of Nursing or designee will audit all new admissions weekly, then monthly until compliance is achieved and report back to the Quality Assurance Program Improvement program. _____ _____ 5. Date of Compliance: All corrective actions will be completed by: June 20th, 2025	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify,	F 580		6/20/25

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F 580	Continued From page 4 consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in	F 580		

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F 580	Continued From page 5 §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the attending physician of a change in condition for 1 of 1 residents (R46) reviewed for new onset of tardive dyskinesia symptoms (repetitive, involuntary movements) often caused by antipsychotic medications. Findings include: R46's quarterly Minimum Data Set (MDS) dated 4/16/25, indicated R46 admitted to the facility on 11/15/24, had severe cognitive impairment, and diagnoses included Alzheimer's disease, delusional disorders, and anxiety disorder. R46's care plan revised 4/23/25, identified psychotropic drug use, and approaches included Abnormal Involuntary Movement Scale (AIMS) assessment per pharmacy recommendation, and physician notified of changes in condition. R46's Order History report, printed 4/24/25, indicated R46 was prescribed increasing doses of quetiapine (antipsychotic medication) for delusional disorder as follows: - admission order quetiapine 12.5mg at bedtime - increased quetiapine to 25mg at bedtime on 11/19/24 - increased quetiapine to 25mg twice a day	F 580	Deficiency: Facility failed to notify the attending physician of change in condition for 1 of 1 (R46) resident reviewed for new onset of tardive dyskinesia symptoms (repetitive, involuntary movements) often caused by antipsychotic medications. Tag Number: F580 _____ 1. Immediate Corrective Action: R46s medical provider was updated immediately after the discrepancy was noted on her AIMS assessment April 22nd, 2025. A comprehensive reassessment of the resident was completed by the interdisciplinary team on April 22nd, 2025. _____ 2. Identification of Other Residents at Risk and Action Taken: The Director of Nursing and staff RN reviewed all residents currently receiving antipsychotic medications on April 28th, 2025, to identify any signs of tardive dyskinesia or other adverse effects. AIMS assessments were reviewed and provider was informed of all current results. No discrepancies were found._____	

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F 580	Continued From page 6 (BID) on 12/12/24 - increased quetiapine to 50mg BID on 1/3/25 R46's initial AIMS assessment, dated 11/22/24, indicated a score of 0 with no observed involuntary movements. R46's follow-up AIMS assessment, dated 3/27/25, indicated a score of 4 with an "increase in symptoms", and to "continue current plan of care". However, the assessment did not indicate the physician had been notified of the increase in tardive dyskinesia symptoms. R46's clinical record lacked evidence the physician was notified of R46's change in condition. On 4/25/25 at 12:25 p.m., consulting pharmacist (PharmD) stated the purpose of an AIMS assessment was to monitor for tardive dyskinesia symptoms related to antipsychotics, and score changes should be communicated to the provider. PharmD stated it was important to notify the provider so the risks versus benefits could be reviewed, and the provider would need to have rationale documented for continuing the antipsychotic medication. On 4/25/25 at 1:53 p.m., director of nursing (DON) stated the purpose of an AIMS assessment was to monitor for adverse side effects from antipsychotic medications, and nurses were expected to notify the provider. DON stated it was important to notify the prescribing physician for the safety of the resident. DON verified R46's clinical record lacked evidence the nurse had not notified the physician that R46's AIMS score increased from 0 to 4. DON stated	F 580	3. Systemic Changes Implemented: Recurrence will be prevented by: A psycho-active medication audit form that was developed to monitor for completed AIMS assessment and notifying provider of the results. Nursing and clinical staff received re-education on: Recognizing signs and symptoms of tardive dyskinesia. The facilitys policy on Change in Condition Notification, emphasizing prompt physician contact. Completed on April 28th, 2025. _____ 4. Monitoring and Quality Assurance: The Director of Nursing or designee will conduct audits on all residents receiving antipsychotics to ensure compliance with timely physician notification weekly. Then monthly audits will be conducted once compliance is achieved. Findings from audits will be reported monthly to the QA Committee. Any identified trends will result in immediate corrective action and additional staff training. QA Committee will review outcomes and determine if continued monitoring or policy revisions are needed._____ 5. Date of Compliance: All corrective actions will be completed by: June 20th, 2025	

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F 580	Continued From page 7 nurses were expected to document in the clinical record to support the physician had been notified. A policy was requested, but not provided by the facility.	F 580		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure a level II preadmission screening and resident review (PASARR) was completed for 1 of 2 residents (R5) reviewed for PASARR's. Findings Include: R5's quarterly Minimum Data Set (MDS) dated	F 644	Deficiency: Facility failed to ensure a level II preadmission screening and resident review (PASARR) was completed for 1 of 2 residents (R5) reviewed for PASARRs. Tag Number: F644 _____ 1. Immediate Corrective Action: The resident in question was immediately	6/20/25

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F 644	Continued From page 8 2/7/25 indicated R5 was admitted to the facility on 10/9/2024, and had the following diagnoses: Schizophrenia, arthritis, and diabetes. R5's Level 1 PASARR dated 4/30/24, indicated the screening was completed on 4/30/24 and prior to admission, R5 required a level II PASARR screening to be completed. No level II PASARR was found or provided. On 4/23/25 at 8:39 a.m., the social services director (SS)-A stated R5 had come from another facility, and they had used the other facilities completed PASARR for R5's admission. However, they were unaware a Level II PASARR was required until the survey team arrived onsite. SS-A confirmed they were typically responsible for completing the PASARR, and stated they had missed it and confirmed it was never completed. On 4/24/25 at 1:23 p.m., the administrator stated they expected the PASARR screenings to be completed by social services, themselves, or another delegated staff upon admission to the facility, and was important to complete to ensure each resident receives the cares and services they need. A policy related to PASARR was requested and none were provided.	F 644	reviewed for PASARR compliance. A retroactive PASARR screening was conducted and submitted to the appropriate state mental health/developmental disabilities authority. Care plan was updated in accordance with any findings. _____ 2. Identification of Other Residents at Risk and Action Taken: The facilitys PASARR policy was updated to include mandatory documentation of Level II screening before admission. The admissions department now uses a checklist that requires PASARR verification. _____ 3. Systemic Changes Implemented: Reoccurrence will be prevented by: All admissions, social services, and nursing staff were in-serviced on PASARR requirements, including: " Level II screening process. " When and how to refer for Level II evaluation. o Documentation and compliance deadlines. _____ 4. Monitoring and Quality Assurance: The Director of Nursing or designee will perform: " Weekly audits of new admissions for the next 90 days to ensure PASARR compliance. " Ongoing monthly QA meetings will include PASARR compliance review.	

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	245412	A. BUILDING _____ B. WING _____	04/25/2025

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F 644	Continued From page 9	F 644	Non-compliance will trigger immediate administrative review and retraining. _____ _____ 5. Date of Compliance: All corrective actions will be completed by: June 20th, 2025	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656		6/20/25

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F 656	Continued From page 10 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a comprehensive care plan was developed and maintained to ensure proper interventions were in place to prevent falls/lessen the likelihood of injury for 1 of 2 residents (R8) reviewed for falls. Findings include: R8's quarterly Minimum Data Set (MDS) assessment dated 4/16/25, indicated severe cognitive impairment without hallucinations or delusions present, and no behaviors. Section J: Health indications indicated R8 had two or more falls without injury and two or more falls with minor injury since admission. Section O: Special Treatments and Programs indicated R8 was not currently receiving physical or occupational therapies. R8's Face sheet printed 4/25/25, indicated R8 admitted to the facility on 8/24/24. Furthermore, it	F 656	Deficiency: Facility failed to ensure a comprehensive care plan was developed and maintained to ensure proper interventions were in place to prevent falls/lessen the likelihood of injury for 1 of 2 residents (R8) reviewed for falls. Tag Number: F656 _____ 1. Immediate Corrective Action: When made aware of deficiency DON reviewed and updated R8 care plan to include individualized fall prevention interventions based on their assessed risks and needs. Date: April 24th, 2025. _____ 2. Identification of Other Residents at Risk and Action Taken: A comprehensive audit of all current residents with falls in the last 60 days or	

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F 656	Continued From page 11 also identified the following relevant diagnoses: osteoarthritis (degeneration of joints that causes pain and stiffness), weakness, and mixed incontinence. R8's care plan reviewed on 4/22/25, indicated R8 received assistance with mobility and was at risk for falls due to physical limitations, incontinence, and poor safety awareness. R8's progress notes indicated 23 documented falls between 10/8/24 and 4/16/25. During observation on 4/21/25 at 03:30 p.m., R8 was in room, seated in wheelchair with feet propped on bed, crossed at ankle. Door was open approximately 3-4 inches and had to be pushed open to fully view resident. Call light was on bed between pillow and wall, out of resident's reach. During observation on 4/21/25 at 5:52 p.m., R8's door was open approximately 3-4 inches. Left back wheelchair wheel was observed, however, could not visualize resident fully. During observation on 4/22/25 at 12:34 p.m. room door was opened and R8 was fully visible. Wheelchair brakes were unlocked, and resident was observed to be leaning forward sitting on edge of seat reaching for objects in room chair. Call light was on the bed pillow outside of resident's. Staff alerted. During interview on 4/24/25 at 3:37 p.m., certified nursing assistant (CNA)-C stated she was familiar with R8 and knew she was a high fall risk. CNA-C went on to say she knew R8 had fall interventions, however, was unaware of what they	F 656	who are at risk for falls will be conducted. Each of their care plans will be reviewed to ensure appropriate and individualized fall prevention interventions are present, up-to-date, and implemented. Completed April 28th, 2025. _____ 3. Systemic Changes Implemented: The fall policy and procedure was reviewed and updated. Staff were educated on fall interventions and location. Nursing staff and MDS coordinator were re-educated on care plan documentation requirements specific to fall risk and interventions on the care plan. _____ 4. Monitoring and Quality Assurance: The Director of Nursing (DON) or designee will conduct weekly audits for 4 weeks, then monthly for 3 months, on a sample of care plans for residents at risk for falls to ensure interventions are in place, individualized, and implemented. Findings will be reviewed during the monthly Quality Assurance and Performance Improvement (QAPI) meetings. Action plans will be developed for any recurring issues. _____ 5. Date of Compliance: All corrective actions will be completed by: June 20th, 2025	

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F 656	Continued From page 12 were or where to find them. During interview 4/24/25 at 3:42 p.m., CNA-D stated she frequently worked with R8 and was familiar with her needs. CNA-D stated she could recognize a high fall risk resident by whether or not they wore grippy socks. CNA-D went on to state she was aware R8 had multiple falls but was unable to identify any fall interventions or need for grippy socks. During interview on 4/24/25 at 4:57 p.m., Director of Nursing (DON) stated all high fall risk residents would have a care plan focus area for falls which would include staff interventions. DON stated all falls were reviewed and a root cause analyses was completed. Further DON stated falls were reviewed by the interdisciplinary team (IDT) with fall interventions updated as needed. DON stated she was aware R8 had more than 10 falls since admission but was unsure exactly how many. She went on to state for residents with a high risk for falls she would expect to see care plan fall interventions to include the bed in the lowest position, a ridged mattress, keep resident in line of vision of staff or common area, grippy socks and a toileting plan. DON confirmed R8's care plan had not been updated after each fall and had limited interventions listed. DON stated it was important to keep care plans updated to ensure resident safety and prevent major injuries. Facility policy titled Nursing Department Care Plan Documentation/Quarterly indicated all care plans would be updated quarterly and as needed and the updates will reflect close evaluation care plan problems, goals and approaches.	F 656		
F 657 SS=E	Care Plan Timing and Revision	F 657		6/20/25

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F 657	Continued From page 13 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to ensure care conferences were conducted to include input of the resident or resident representatives for 5 of 11 (R10, R19, R20, R21, and R43) residents reviewed for care conferences. Findings include:	F 657	Deficiency: Facility failed to ensure care conferences were conducted to include input of the resident or resident representatives for 5 of 11 (R10, R19, R20, R21, and R43) residents reviewed for care conferences. Tag Number: F657	

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F 657	Continued From page 14 R10's quarterly Minimum Data Set (MDS) dated 3/14/2025 indicated R10 was severely cognitively impaired and had the following diagnoses: hypertension (HTN) (high blood pressure), arthritis, and Dementia. R10's Care Plan last revised 3/17/25 indicated, R10 had cognitive loss, impaired decision-making skills, and memory deficits. R 10's medical record lacked any documentation the resident, resident representative or family members had been contacted prior to having care conferences for R10 and the implementation of any changes to the care plan. R10's Care Plan Summary dated 3/26/25, indicated input from nursing, social services, and dietary. However, lacked any indication of involvement from resident, resident representative or family members. R19 annual MDS dated 2/21/25, indicated R19 was rarely or never understood, cognition was severely impaired and had the following diagnoses: Dementia, and a seizure disorder. R19's care plan last revised 3/6/25, indicated R19 has a diagnosis of dementia, tends to wander and have anxiety when they do not know where they are. R19's care plan also indicated they communicate through their teddy bear, which they feel is alive. R 19's medical record lacked any documentation the resident, resident representative or family members had been contacted prior to having care conferences for R19 and the implementation	F 657	1. Immediate Corrective Action: The facility immediately reviewed care conference documentation for the residents identified during the survey. Residents and/or their representatives were contacted on April 26th, 2025, and care conferences were reconvened to ensure their input was solicited and documented. Care plans were updated accordingly to reflect their preferences and goals. 2. Identification of Other Residents at Risk and Action Taken: A comprehensive audit of all residents admitted within the past 90 days was conducted to determine if care conferences occurred without resident or representative input. Any instances where input was not documented were corrected by initiating contact with the resident or representative and revising the care plan as needed. 3. Systemic Changes Implemented: Reoccurrence will be prevented by: Care conference protocols were revised to include mandatory documentation of resident or representative participation or efforts to obtain input. A new checklist was implemented for the interdisciplinary team to verify participation or refusal prior to finalizing the care plan. Staff responsible for care conferences (e.g., social workers, MDS coordinators) were re-educated on the importance of	

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F 657	Continued From page 15 of any changes to the care plan. R19's Care Plan Summary dated 3/12/25, indicated input from nursing, social services, and dietary. However, lacked any indication of involvement from resident, resident representative or family members. R20 quarterly MDS dated 3/1/25, indicated R20 was severely cognitively impaired and had the following diagnoses: HTN, arthritis, Alzheimer's, hemiparesis or hemiplegia (inability to use one side of one's body), and anxiety. R20's Care plan last revised 3/14/25 indicated R20 has short- and long-term memory issues, impaired decision-making abilities, and required frequent orientation to daily task of living. Also, tended to wander and was unaware of where they were. R 20's medical record lacked any documentation the resident, resident representative or family members had been contacted prior to having care conferences for R20 and the implementation of any changes to the care plan. R20's Care Plan Summary dated 3/25/25, indicated input from nursing, social services, and dietary. However, lacked any indication of involvement from resident, resident representative or family members. R21's quarterly MDS dated 3/14/25, indicated R21 was severely cognitively impaired and had the following diagnoses: HTN, Alzheimer's, and dementia. R21's Care plan last revised 3/20/25 indicated	F 657	resident/representative involvement with care planning. Facility policy was updated to include alternate methods for obtaining input (e.g., phone, video call) when in-person participation is not feasible. _____ 4. Monitoring and Quality Assurance: The Director of Nursing or Designee will review 100% of care conferences weekly for 4 weeks to ensure documentation of resident/representative involvement. If compliance is maintained, audits will continue monthly for 3 months. Findings will be reported to the QAPI committee monthly. Any noncompliance will result in immediate staff re-education and corrective actions. _____ 5. Date of Compliance: All corrective actions will be completed by: June 20th, 2025	

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F 657	Continued From page 16 R21 has a diagnoses of Alzheimer's and dementia, and short-term memory loss. R 21's medical record lacked any documentation the resident, resident representative or family members had been contacted prior to having care conferences for R21 and the implementation of any changes to the care plan. R21's Care Plan Summary dated 3/26/25, indicated input from nursing, social services, and dietary. However, lacked any indication of involvement from resident, resident representative or family members. R43's admission MDS dated 3/4/25, indicated R43 was severely cognitively impaired, and had the following diagnoses: Parkinson's, heart failure (failure of the heart to pump effectively), HTN, and a hip fracture. R43's care plan last revised 3/10/25, indicated severe cognitive impairment, and short-term memory deficits. R 43's medical record lacked any documentation the resident, resident representative or family members had been contacted prior to having care conferences for R43 and the implementation of any changes to the care plan. R43's Care Plan Summary dated 3/25/25, indicated input from nursing, social services, and dietary. However, lacked any indication of involvement from resident, resident representative or family members. On 4/21/25 at 4:11 p.m., during a phone interview, family member (FM)-G stated they had	F 657		

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F 657	Continued From page 17 never been made aware or included in any care conferences or asked to provide any input regarding R21's treatment and services. Furthermore, FM-G stated they would have to like to be included in those discussions. On 4/24/25 during multiple interviews at 12:57 p.m. and 1:51:p.m., social services director (SS)-A stated she was responsible for care conferences. She sent out the care plan summary to the included facility staff to add their input. Once compiled, the staff reviewed it, and SS-A sent it to the family via postal mail for review. Family may or may not request a care conference after review. SS-A stated a cover letter was sent with the care conference summary. If the family did not respond or have questions, no meeting was conducted in the facility. SS-A confirmed she conducted one to one meetings with residents, but it was after the care plan was revised. Further, SS-A stated confused residents may be able to answer yes/no questions, they may not be the best advocate for themselves. On 4/24/25 at 3:44 p.m., the administrator stated their expectation was, care conferences were to be conducted to communicate the needs of the resident, and to update the family of any change in condition, new needs or any new concerns. The administrator stated in the past the facility had had issues with getting family to participate so they changed their process to sending out the summary after it was completed. The administrator stated they needed a process change to get families more involved in guiding care. The administrator stated the importance of care conferences being conducted with the input of the resident and/or their representative to be	F 657		

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F 657	Continued From page 18 sure the residents' cares and needs were met. The facility Person-Centered Care Planning Policy and Procedure last reviewed 1/2025, indicated the care plans will be reviewed at a care planning meeting with the resident and/or representative and a summary shared with the resident/representative.	F 657		
F 741 SS=D	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.71. These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.71, and §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by:	F 741		6/20/25

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F 741	Continued From page 19 Based on interview, and document review, the facility failed to ensure non-pharmacological interventions were attempted prior to the administration of psychotropic medications (mood altering medications) for 1 of 1 residents (R7) reviewed for as needed (PRN) psychotropic medications. Findings include: R7's quarterly Minimum Data Set (MDS), dated 3/14/25, indicated R7 had severe cognitive impairment, and exhibited verbal behavioral symptoms directed toward others one to three times during the assessment period. R7's diagnoses included dementia, delusional disorders, and depression. R7's care plan, revised 3/21/25, identified the potential for psychosocial distress, and approaches included reassurance, encourage activity of choice, 1:1 visits, and redirection. R7's Order History report, printed 4/25/25, indicated an order dated 3/24/25 for lorazepam 0.25mL (0.5mg) every 4 hours PRN for anxiety/agitation, with a stop date of 4/6/25. R7's PRN Psychotropic Medication Monitoring log for "PRN Med: Lorazepam" indicated approaches to try prior to medication administration included redirection, 1:1, ensure calm environment, rule out pain/discomfort, rule out hunger/thirst, and rule out toileting need. The last notation made by staff on the log was dated 10/12/23. R7's Target Behavior Monitoring logs indicated R7's target behaviors were "delusions" and "anxiety/agitation", and staff were to document	F 741	Deficiency: Facility failed to ensure non-pharmacological interventions were attempted prior to the administration of psychotropic medications (mood altering medications) for 1 of 1 residents (R7) reviewed for as needed (PRN) psychotropic medications. Tag Number: F741 1. Immediate Corrective Action: The resident(s) identified in the deficiency were reassessed immediately by the interdisciplinary team. Non-pharmacological intervention strategies were reviewed, individualized, and implemented in the care plan and MAR. 2. Identification of Other Residents at Risk and Action Taken: A review of all residents currently prescribed PRN psychotropic medications was completed to ensure documentation of attempted non-pharmacological interventions. 3. Systemic Changes Implemented: Policy Update: Facility policy was revised to require documentation of non-pharmacological interventions prior to administration of PRN psychotropic medications. Behavior monitoring sheets have been updated and Audit form to ensure documentation of non-pharmacological interventions	

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F 741	Continued From page 20 the number of episodes, management intervention(s), and results every shift. R7's Medication Administration Record (MAR) dated 3/1 to 3/31/25, indicated lorazepam 0.25mL (0.5mg) was administered to R7 on 3/25/25 at 12:38 a.m. for "behavior issue". However, R7's Target Behavior Monitoring log for March 2025 lacked documentation of target behavior episode(s) and management intervention(s) for 3/25/25 NOC (overnight) shift. Additionally, R7's clinical record lacked evidence non-pharmacological interventions had been attempted prior to administration of the PRN psychotropic. R7's Medication Administration Record (MAR) dated 4/1 to 4/24/25, indicated lorazepam 0.25mL (0.5mg) was administered to R7 on 4/2/25 at 1:21 a.m. for "behavior issue". However, R7's Target Behavior Monitoring log for April 2025 lacked documentation of target behavior episode(s) and management intervention(s) for 4/2/25 NOC (overnight) shift. Additionally, R7's clinical record lacked evidence non-pharmacological interventions had been attempted prior to administration of the PRN psychotropic. R7's Medication Administration Record (MAR) dated 4/1 to 4/24/25, indicated lorazepam 0.25mL (0.5mg) was administered to R7 on 4/5/25 at 12:26 a.m. for "other reason". However, R7's Target Behavior Monitoring log for April 2025 indicated R7 had "0" target behavior episodes 4/5/25 NOC (overnight) shift.	F 741	Education: Staff received education regarding the required steps prior to PRN psychotropic administration, including proper documentation of attempted interventions. Care Plan: Behavior care plans were updated to include individualized, person-centered non-pharmacologic interventions for residents prescribed psychotropics. EMR Prompt: Electronic charting system updated to require staff to document attempted non-pharmacologic strategies before allowing PRN psychotropic medication administration entry. 4. Monitoring and Quality Assurance: The Director of Nursing (DON) or designee will audit all residents receiving PRN psychotropics weekly for 1 month, then monthly until compliance is met, to ensure proper documentation and use of non-pharmacologic strategies. Findings will be reported to the Quality Assurance & Performance Improvement (QAPI) Committee monthly. 5. Date of Compliance: All corrective actions will be completed by: June 20th, 2025	

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F 741	Continued From page 21 Additionally, R7's clinical record lacked evidence non-pharmacological interventions had been attempted prior to administration of the PRN psychotropic. On 4/25/25 at 12:25 p.m., consulting pharmacist (PharmD) stated non-pharmacological interventions prior to administration of PRN psychotropics should be care planned and non-pharmacological interventions should be attempted prior to the administration of PRN psychotropics unless a severe situation of psychosis with potential for harm. On 4/25/25 at 1:53 p.m., director of nursing (DON) verified R7's clinical record lacked evidence of non-pharmacological interventions prior to the administration of PRN psychotropic on 3/25/25, 4/2/25, and 4/5/25. DON stated staff were expected to administer PRN psychotropic medications as ordered for the identified target behaviors. DON stated staff were expected to attempt and document non-pharmacological interventions prior to administration of PRN psychotropics. A policy was requested, but not provided by the facility	F 741		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756		6/20/25

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F 756	Continued From page 22 §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure consulting pharmacist (PharmD) identified the facility's lack of target behavior monitoring in the monthly medication regimen review (MRR) for 1 of 5 residents (R46) reviewed for unnecessary psychotropic medications.	F 756	Deficiency: Facility failed to ensure consulting pharmacist (PharmD) identified the facilitys lack of target behavior monitoring in the monthly medication regiment review (MMR) for 1 of 5 residents (R46) reviewed for unnecessary psychotropic medications.	

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F 756	Continued From page 23 Findings include: R46's quarterly Minimum Data Set (MDS) dated 4/16/25, indicated R46 admitted to the facility on 11/15/24, had severe cognitive impairment, and diagnoses included Alzheimer's disease, delusional disorders, and anxiety disorder. R46's order summary, printed 4/25/25, indicated R46 had the following psychotropic medication orders: - paroxetine (antidepressant) 40 mg daily for panic disorder - quetiapine 50 mg BID for delusional disorders R46's November 2024 Target Behavior Monitoring log identified target behaviors anxiety, agitation, feeling down, depressed, and hopeless, and the log indicated target behaviors were monitored 8 of 45 shifts. Additionally, R46's clinical record lacked evidence of documented target behavior monitoring from 12/1/24 through 4/22/25. R46's progress note, dated 04/07/25 at 6:11 a.m., indicated medications were reviewed by PharmD, and no problems identified. However, the MRR failed to identify the facility's lack of target behavior monitoring for R46's psychotropic medication use. R46's progress note, dated 03/09/25 at 10:23 a.m., indicated medications were reviewed by PharmD, and a gradual dose reduction (GDR) was recommended as follows: 1. Please evaluate and document ongoing need for paroxetine for anxiety and quetiapine for	F 756	Tag Number: F756 1. Immediate Corrective Action: Primary provider updated on April 25, 2025, to initiate appropriate target behaviors for psychotropic medications. The consulting pharmacist has been notified, May 21, 2025, of the oversight in the medication regimen review regarding the lack of target behavior monitoring for affected residents. 2. Identification of Other Residents at Risk and Action Taken: A complete audit of all residents receiving psychotropic medications was conducted on May 21, 2025, to identify any additional instances where behavior monitoring was not documented appropriately. 3. Systemic Changes Implemented: The Director of Nursing (DON) will review the monthly MRR to ensure target behavior monitoring was reviewed. Education was provided to the consulting pharmacist on the importance of reviewing and identifying missing behavior monitoring during the monthly regimen review. Nursing staff were re-educated on documenting target behaviors consistently and accurately. 4. Monitoring and Quality Assurance: The Director of Nursing or designee will audit the behavior monitoring	

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F 756	Continued From page 24 delusions. Document target behaviors and symptoms being controlled. Consider attempting dose reduction if appropriate. However, the MRR failed to identify the facility's lack of target behavior monitoring for R46's psychotropic medication use. R46's progress note, dated 02/02/25 at 09:10 a.m., indicated medications were reviewed by PharmD, and no problems identified. However, the MRR failed to identify the facility's lack of target behavior monitoring for R46's psychotropic medication use. R46's progress note, dated 1/6/25 at 9:47 a.m., indicated medications were reviewed by PharmD, and the following recommendations were made: 1. Recommend monitoring orthostatic blood pressure monthly while on Seroquel. If unable to obtain orthostatic blood pressure, please document reason. Recommend entering order into matrix for monthly orthostatic blood pressures. 2. Patient is noted to have multiple falls recently. Paxil and Seroquel may contribute. Seroquel dose has been increased twice in the last month. Determine if medications are contributing to falls and if benefits outweigh risks of medications. 3. Recent lipid panel showed elevated triglycerides, LDL, and total cholesterol. Consider adding lipid lowering medication such as atorvastatin. However, the MRR failed to identify the facility's lack of target behavior monitoring for R46's psychotropic medication use. R46's progress note, dated 1/6/25 at 9:47 a.m., indicated medications were reviewed by PharmD, and to review report for recommendations.	F 756	documentation weekly, then monthly until compliance is met. Audit findings will be discussed in the monthly Quality Assurance and Performance Improvement (QAPI) committee meetings for six months or until substantial compliance is maintained. _____ _____ 5. Date of Compliance: All corrective actions will be completed by: June 20th, 2025	

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F 756	Continued From page 25 However, the MRR failed to identify the facility's lack of target behavior monitoring for R46's psychotropic medication use. On 4/25/25 at 12:25 p.m., consulting pharmacist (PharmD) stated every psychotropic medication needed identified target behaviors. Staff are expected to monitor the identified target behaviors, and the monitoring should be documented so the provider can identify if behaviors have increased. On 4/25/25 at 1:53 p.m., director of nursing (DON) verified R46's clinical record lacked evidence of target behavior monitoring from 12/1/24 through 4/22/25. DON stated nurses were expected to initiate target behavior monitoring when the provider ordered a psychotropic medication. DON stated target behavior monitoring was necessary, so providers know if a psychotropic medication has been effective/ineffective and if target behaviors have increased/decreased. DON stated the target behavior monitoring is important so providers can determine if a psychotropic medication is appropriate. The facility's Pharmacy Consultant Expectations Policy, revised 2/24, indicated to meet the needs of each resident accurately and safely, by collaborating with the licensed pharmacist, serving as consultant, to guide the facility with a system consistent with clinical best practice, quality resident care, and regulatory compliance for pharmacy services in the facility. Additionally, the consulting pharmacist would conduct monthly medication regimen review (MRR) for each resident to address irregularities.	F 756		

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F 758	Continued From page 26	F 758		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or	F 758		6/20/25

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F 758	Continued From page 27 prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure target behaviors were consistently monitored for 5 of 5 residents (R7, R28, R30, R46, R1) reviewed for unnecessary psychotropic medication use. Findings include: R7's quarterly Minimum Data Set (MDS), dated 3/14/25, indicated R7 admitted to the facility on 3/9/22, had severe cognitive impairment, and diagnoses included dementia, delusional disorders, and depression. R7's order summary, printed 4/25/25, indicated R7 had the following psychotropic medication orders: lorazepam concentrate (antianxiety) 0.25 mL (0.5 mg) twice a day (BID) for anxiety disorder quetiapine (antipsychotic) 25 mg daily for dementia with other behavioral disturbance Sertraline (antidepressant) 100 mg daily for dementia with other behavioral disturbance R7's target behavior monitoring lacked consistent	F 758	Deficiency: Facility failed to ensure target behaviors were consistently monitored for 5 of 5 residents (R7, R28, R30, R46 and R1) reviewed for unnecessary psychotropic medication use. Tag Number: F758 1. Immediate Corrective Action: Primary provider updated on April 25, 2025, to initiate appropriate target behaviors for psychotropic medications. The consulting pharmacist was notified on April 25, 2025, of the oversight in the medication regimen review regarding the lack of target behavior monitoring for affected residents. 2. Identification of Other Residents at Risk and Action Taken: A complete audit of all residents receiving psychotropic medications was conducted to identify any additional instances where behavior monitoring was not documented appropriately.	

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F 758	Continued From page 28 monitoring for the identified target behaviors anxiety, agitation, and delusions. R7's Target Behavior Monitoring logs from 10/1/24 through 4/20/25, indicated the following: April 2025 - 44 of 60 shifts documented March 2025 - 48 of 93 shifts documented February 2025 - 44 of 84 shifts documented January 2025 - 39 of 93 shifts documented December 2024 - 44 of 93 shifts documented November 2024 - 48 of 93 shifts documented October 2024 - 52 of 93 shifts documented R28's annual MDS, dated 2/21/25, indicated R28 had severe cognitive impairment, and diagnoses including dementia, and depression. R28's order summary printed 4/25/25, indicated R28 had the following psychotropic medication orders: Olanzapine (antipsychotic) 2.5 mg orally (by mouth) at bedtime for auditory hallucinations. Sertraline (antidepressant) 100 mg daily for major depressive disorder. Zoloft (Sertraline- trade name of drug above) (antidepressant) 50 mg daily for total dose of 150 mg daily, for major depressive disorder. R28's target behavior monitoring lacked consistent monitoring for the identified target behaviors feeling down, depressed or hopeless, insomnia, and auditory hallucinations. R28's Target Behavior Monitoring Logs from 10/1/24 through 4/20/25 indicated the following: April 2025: 47 of 60 shifts documented. March 2025: 44 of 93 shifts documented. February 2025: 36 of 84 shifts documented.	F 758	Completed on April 28, 2025. _____ 3. Systemic Changes Implemented: The Director of Nursing (DON) or designee will review the monthly MRR to ensure target behavior monitoring was reviewed. Education was provided to the consulting pharmacist on the importance of reviewing and identifying missing behavior monitoring during the monthly regimen review. Nursing staff were re-educated on documenting target behaviors consistently and accurately. _____ 4. Monitoring and Quality Assurance: The Director of Nursing or designee will audit the behavior monitoring documentation weekly, then monthly until compliance is met. Audit findings will be discussed in the monthly Quality Assurance and Performance Improvement (QAPI) committee meetings for six months or until substantial compliance is maintained. _____ 5. Date of Compliance: All corrective actions will be completed by: June 20th, 2025	

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January 2025: 48 of 93 shifts documented.
December 2024: 52 of 93 shifts documented.
November 2024: 57 of 90 shifts documented.
October 2024: 37 of 93 shifts documented.

R30's quarterly Minimum Data Set (MDS), dated 3/14/25, indicated R30 admitted to the facility on 3/24/22, had severe cognitive impairment, and diagnoses included dementia and anxiety disorder.

R30's order summary, printed 4/25/25, indicated R30 had the following psychotropic medication orders:

lorazepam 0.5 mg three times a day (TID) for anxiety disorder
olanzapine (antipsychotic) 5 mg BID for delusions due to Korsakoff syndrome (neuropsychiatric condition affecting memory)

R30's target behavior monitoring lacked consistent monitoring for the identified target behaviors anxiety and distressing delusions. R30's Target Behavior Monitoring logs from 10/1/24 through 4/20/25, indicated the following:

April 2025 - 39 of 60 shifts documented
March 2025 - 39 of 93 shifts documented
February 2025 - 45 of 84 shifts documented
January 2025 - 39 of 93 shifts documented
December 2024 - 45 of 93 shifts documented
November 2024 - 48 of 93 shifts documented
October 2024 - 53 of 93 shifts documented

R46's quarterly Minimum Data Set (MDS) dated 4/16/25, indicated R46 admitted to the facility on 11/15/24, had severe cognitive impairment, and diagnoses included Alzheimer's disease,

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F 758	Continued From page 30 delusional disorders, and anxiety disorder. R46's order summary, printed 4/25/25, indicated R46 had the following psychotropic medication orders: paroxetine (antidepressant) 40 mg daily for panic disorder quetiapine 50 mg BID for delusional disorders R46's target behavior monitoring lacked consistent monitoring for the identified target behaviors anxiety, agitation, feeling down, depressed, and hopeless. R46's Target Behavior Monitoring logs from 11/15/24 through 4/20/25, indicated the following: April 2025 - no evidence of documented target behavior monitoring found in clinical record March 2025 - no evidence of documented target behavior monitoring found in clinical record February 2025 - no evidence of documented target behavior monitoring found in clinical record January 2025 - no evidence of documented target behavior monitoring found in clinical record December 2024 - no evidence of documented target behavior monitoring found in clinical record November 2024 - 8 of 45 shifts documented R1 quarterly minimum data set (MDS) dated 12/13/24 indicated R1 was admitted to the facility on 5/1/2018, was cognitively impaired and had the following diagnoses: anxiety, bipolar disease and schizophrenia (a chronic mental disorder characterized by symptoms such as hallucinations, delusions and cognitive challenges). R1's order summary printed 4/25/25 indicated R1	F 758		

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took following medications: Depakote ER 1000 mg once daily for Schizophrenia, Ziprasidone 80 mg twice daily for Schizophrenia, Seroquel 100 mg twice daily for Schizophrenia, and Wellbutrin XL 300 mg once daily for bipolar disorder. The order summary also indicated an order to monitor affect/alertness, increased delusions that are distressing to resident and unable to manage with staff interventions; update primary care provider for worsening symptoms.

Review of R1's Target Behavior monitoring for January 2025 through April 2025 lacked consistent monitoring for distressing delusions, hallucinations, and increased anxiety with many days left blank with no documentation of monitoring taking place.

On 4/25/25 at 12:25 p.m., consulting pharmacist (PharmD) stated every psychotropic medication needed identified target behaviors. Staff were expected to monitor the identified target behaviors. The monitoring needed to be documented so the provider can identify if behaviors had increased.

On 4/25/25 at 1:53 p.m., director of nursing (DON) stated staff were expected to document for target behaviors every shift. The DON stated she was aware there were "holes in the monitoring, and verified the target behavior monitoring documentation was not maintained appropriately for R7, R28, R30, R46 and R1. DON stated target behavior monitoring was necessary, so providers know if a psychotropic medication had been effective/ineffective and if target behaviors had increased/decreased. DON stated the target behavior monitoring was important so providers can determine if a

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F 758	Continued From page 32 psychotropic medication was appropriate. The facility's Psychotropic Target Behavior Monitoring Policy, last reviewed 6/23, indicated target behavior monitoring would be initiated with the use of antipsychotic/neuroleptic medications to meet state/federal/pharmacy behavior monitoring guidelines/recommendations. Additionally, the MDS nurse would tally results at the end of each month.	F 758		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement	F 868		6/20/25

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	245412	A. BUILDING _____ B. WING _____	04/25/2025

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

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F 868	Continued From page 33 projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on document review, and interview the facility failed to ensure Quality Assurance Performance Improvement (QAPI) meetings were held on a quarterly basis. This practice had the potential to affect all 53 residents residing in the facility. Findings include: Review of the QAPI meeting minutes agendas identified QAPI meetings were held on 4/16/24, 8/27/24, and 1/7/25 outside of the required time frame of every 3 months or quarterly. On 4/25/25 at 2:06 p.m., the director of nursing confirmed they were the lead for the QAPI meetings, and the facility had not been meeting quarterly and stated they should have completed one more meeting to have been in compliance. The facility's Quality Assurance and Performance Improvement Plan effective date 1/2025, indicated the QAPI committee was responsible for meeting, at a minimum, on a quarterly basis; more frequently, if necessary.	F 868	Deficiency: Facility failed to ensure Quality Assurance Performance Improvement (QAPI) meetings were held on a quarterly basis. Tag Number: F868 1. Immediate Corrective Action: The Director of Nursing (DON) scheduled a Quality Performance and Improvement meeting upon identification of the deficiency and was conducted on May 6th, 2025. Meeting minutes were documented and QAPI meeting requirement reviewed with members. 2. Identification of Other Residents at Risk and Action Taken: A review of the facility system and services was initiated to determine if any quality concerns had not been identified or addressed due to the missed meetings. No negative outcomes were noted at this time.	

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F 868	Continued From page 34	F 868	3. Systemic Changes Implemented: The DON and department heads have been re-educated on the importance of the quarterly QAPI meetings and their role in the QAPI process. Attendance and meeting minutes will be maintained and audited to ensure compliance. A QAPI meeting is scheduled every month for 6 months, and then quarterly, the DON will send out a reminder to QAPI members at least 1 week prior to the meeting. _____ 4. Monitoring and Quality Assurance: The DON or designee will audit QAPI meeting compliance quarterly for the next 6 months to ensure meetings are held as scheduled. Results will be reported to the QAPI program for review. _____ 5. Date of Compliance: All corrective actions will be completed by: June 20th, 2025	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		6/20/25

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F 880	Continued From page 35 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed	F 880		

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F 880	Continued From page 36 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, and interview the facility failed to conduct appropriate hand hygiene during medication administration for 1 of 3 staff members observed during medication administration. This had the potential to affect at 53 residents in residence at the facility. Findings include: On 4/22/25 at 11:47 a.m., trained medication aide (TMA)-A was observed giving medications to a resident in the main sitting area of the facility. TMA-A then returned to the medication room, where writer was waiting to observe the medication administration. TMA-A agreed to be observed, TMA-A then began preparing medications for a second resident, however, did not perform hand hygiene prior to starting the second medication administration. TMA-A proceeded to administer medications to the second resident, and then returned to the medication cart. TMA-A then began a third resident's medications, and did not perform	F 880	Deficiency: Facility failed to conduct appropriate hand hygiene during medication administration for 1 of 3 staff members observed during medication administration. Tag Number: F880 _____ 1. Immediate Corrective Action: When the discrepancy was noted, the staff member was immediately educated on proper hand hygiene protocols on April 22nd, 2025. The Infection Preventionist observed and verified that proper hand hygiene was performed for the remainder of the shift. _____ 2. Identification of Other Residents at Risk and Action Taken: The Director of Nursing (DON)/Infection Preventionist (IP) will educate nursing staff on infection control practices related	

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F 880	Continued From page 37 proper hand hygiene, in between residents. TMA-A then administered the medications to the third resident, came back to the cart, stated they were finished. TMA-A failed to complete hand hygiene after completing all medication administrations. On 4/22/25 at approximately 12:00 p.m., TMA-A requested assistance with another staff member, licensed practical nurse (LPN)-B, who was present in the room during the observation. TMA-A then stated they should have preformed hand hygiene before and after each resident and in between residents when passing medications. TMA-A confirmed they did not perform hand hygiene appropriately and stated hand hygiene was important to prevent spread of infection. On 4/22/25 at approximately 12:20 p.m., the director of nursing (DON) stated they expected staff members conducting medication administration to perform hand hygiene before and after all medication administrations, and in between residents. The DON stated the importance of completing appropriate hand hygiene to prevent the spread of infection within the facility. The facility's Hand Washing/Hygiene Policy last revised 2/24, indicated hand washing will be completed between resident care and whenever direct physical contact of resident occurs.	F 880	to hand hygiene. _____ 3. Systemic Changes Implemented: The DON or designee will perform hand hygiene audits 3 times a week for 4 weeks, then weekly for 2 months, and then monthly. _____ 4. Monitoring and Quality Assurance: The Director of Nursing or designee will perform hand hygiene audits 3 times a week for 4 weeks, then weekly for 2 months, and then monthly to achieve compliance. Results will be reported to Quality Assurance committee. _____ 5. Date of Compliance: All corrective actions will be completed by: June 20th, 2025	
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 881		6/20/25

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F 881	Continued From page 38 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure prescribed antibiotics met criteria for antibiotic use. Further, the facility failed to assess for continued need of the antibiotics to help reduce unnecessary antibiotic use and reduce potential drug resistance were completed for 1 of 1 residents (R31) reviewed for antibiotic use. This had the potential to affect any of the 53 residents who resided in the facility who might use antibiotics. Findings include: R31's quarterly Minimum Data Set (MDS) dated 3/7/25, indicated R31 was cognitively intact, had an indwelling urinary catheter, and diagnoses included Parkinson's disease, dementia, and obstructive uropathy (urine flow is obstructed). R31's order history report, dated 4/25/25, indicated an antibiotic was ordered by the provider for cefpodoxime 200mg twice a day (BID) for a diagnosis of urinary tract infection (UTI), with a start date of 3/29/25 and end date of 4/2/25. R31's progress note, dated 3/26/25 at 3:32 p.m., indicated the licensed practical nurse (LPN)-A notified the provider that R31 completed an order for Macrobid (antibiotic) for a positive UTI, with no improvement in dark, cloudy, odorous urine and	F 881	Deficiency: Facility failed to ensure prescribed antibiotics met criteria for antibiotic use. Further, the facility failed to assess for continued need of the antibiotics to help reduce unnecessary antibiotic use and reduce potential drug resistance were completed for 1 of 1 residents (R31) reviewed for antibiotic use. Tag Number: F881 _____ 1. Immediate Corrective Action: The residents currently prescribed antibiotics were immediately reviewed by the provider and the infection preventionist. No concerns identified. Completed on May 6th, 2025. _____ 2. Identification of Other Residents at Risk and Action Taken: A full audit was conducted of all residents who have received antibiotic therapy in the past 30 days, completed on April 28th, 2025. Any instances of antibiotics prescribed without meeting appropriate clinical criteria were referred to the provider for review. _____	

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F 881	Continued From page 39 increased sleeping. The provider ordered a urinalysis (UA). R31's UA results report, verified 3/28/25, indicated the urine specimen contained "many" bacteria, "500 (large)" leukocytes, ">180 (H)" red blood cells, and "negative" nitrite. On 3/28/25, at the bottom of the UA report, the provider wrote an antibiotic order for cefpodoxime 200 mg by mouth (PO) every (q) 12 hours two times a day (BID). Additionally, the order directed the facility to "update the culture and sensitivity ASAP as it may warrant a change in antibiotic". However, the report did not identify it had been reviewed by a nurse. R31's physician order, dated 3/28/25 at 4:46 p.m., indicated "Start Vantin (cefpodoxime) 200 mg PO q12hrs for 5 days", and "I highly recommend they fax and call with culture and sensitivity results". The order was acknowledged in writing by registered nurse (RN)-C. R31's urine culture (UC) results report, verified 3/29/25, indicated "Growth (A) [abnormal] >100,000 CFU/mL mixed bacterial growth" and "Mixed bacterial growth indicates the specimen is likely contaminated at collection with urogenital and/or fecal flora". On 4/1/25, the provider wrote "update with sensitivities", at the bottom of the UC report. However, the report did not identify it had been reviewed by a nurse. R31's clinical record lacked evidence the provider had been notified a "sensitivities" report had not been received. Additionally, R31's clinical record lacked evidence reviewed based on antibiotic stewardship guidelines and criteria.	F 881	3. Systemic Changes Implemented: The facility revised its Antibiotic Stewardship Policy, ensuring alignment with CDC Core Elements and best practices. Weekly antibiotic reviews will be conducted by the Infection Preventionist in collaboration with the Provider. An Antibiotic Time-Out" protocol at 72 hours will be used to reassess ongoing need. All licensed nurses, prescribing providers, and pharmacy consultants received in-service training on: antibiotic stewardship, appropriate prescribing criteria, recognition of adverse drug effects, and timely reassessment. _____ 4. Monitoring and Quality Assurance: The Infection Preventionist will present monthly antibiotic usage reports to the QA Committee. Any trends of inappropriate prescribing will be addressed with targeted interventions. Quarterly audits will be performed to ensure adherence to the revised protocols. Results of audits will be reviewed during QA&A meetings and used to guide performance improvement strategies. _____ 5. Date of Compliance: All corrective actions will be completed by: June 20th, 2025	

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F 881	Continued From page 40 On 4/25/25 at 11:02 a.m., director of nursing (DON) stated she was the facility infection preventionist (IP) and it was her role to oversee the resident infections and antibiotic use. DON stated the facility used McGeer criteria to help identify infections, and Loeb criteria was used to determine when antibiotics were indicated. DON stated R31 had completed taking an antibiotic for a urinary tract infection (UTI) on 3/25/25, but staff reported that R31 was still symptomatic, the provider was notified, and a UA/UC was ordered. DON verified the UC report indicated the sample was likely contaminated and the test had not been repeated. DON confirmed a 72-hour time-out had not been completed. DON stated a 72-hour time-out should have been completed for R31 to identify the provider had not been alerted when UC susceptibilities were not provided. DON stated the antibiotic stewardship guidelines should have been followed to ensure criteria was met and the resident was prescribed the correct antibiotic. DON stated it was important to follow the antibiotic stewardship guidelines to avoid antibiotic resistance. The facility's Antimicrobial Stewardship Policy, revised 2/24, indicated the key objectives include reducing inappropriate antimicrobial use, improving patient care outcomes and mitigating adverse consequences. Additionally, the duration of antimicrobial therapy will be defined and/or regularly reviewed based on evidence-based guidelines (ie. 72-hour antibiotic time out).	F 881		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 13, 2025

Administrator
Cokato Manor
182 Sunset Avenue
Cokato, MN 55321

Re: State Nursing Home Licensing Orders
Event ID: RKHH11

Dear Administrator:

The above facility was surveyed on April 21, 2025, through April 25, 2025, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.



Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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	00712	A. BUILDING: _____ B. WING _____	04/25/2025

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 04/21/25 through 4/25/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,	2 000		

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2 000	Continued From page 2 "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths.	2 265		6/20/25

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	00712	A. BUILDING: _____ B. WING _____	04/25/2025

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2 265	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify the attending physician of a change in condition for 1 of 1 residents (R46) reviewed for new onset of tardive dyskinesia symptoms (repetitive, involuntary movements) often caused by antipsychotic medications. Findings include: R46's quarterly Minimum Data Set (MDS) dated 4/16/25, indicated R46 admitted to the facility on 11/15/24, had severe cognitive impairment, and diagnoses included Alzheimer's disease, delusional disorders, and anxiety disorder. R46's care plan revised 4/23/25, identified psychotropic drug use, and approaches included Abnormal Involuntary Movement Scale (AIMS) assessment per pharmacy recommendation, and physician notified of changes in condition. R46's Order History report, printed 4/24/25, indicated R46 was prescribed increasing doses of quetiapine (antipsychotic medication) for delusional disorder as follows: - admission order quetiapine 12.5mg at bedtime - increased quetiapine to 25mg at bedtime on 11/19/24 - increased quetiapine to 25mg twice a day (BID) on 12/12/24 - increased quetiapine to 50mg BID on 1/3/25 R46's initial AIMS assessment, dated 11/22/24, indicated a score of 0 with no observed	2 265	Corrected	

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2 265	Continued From page 4 involuntary movements. R46's follow-up AIMS assessment, dated 3/27/25, indicated a score of 4 with an "increase in symptoms", and to "continue current plan of care". However, the assessment did not indicate the physician had been notified of the increase in tardive dyskinesia symptoms. R46's clinical record lacked evidence the physician was notified of R46's change in condition. On 4/25/25 at 12:25 p.m., consulting pharmacist (PharmD) stated the purpose of an AIMS assessment was to monitor for tardive dyskinesia symptoms related to antipsychotics, and score changes should be communicated to the provider. PharmD stated it was important to notify the provider so the risks versus benefits could be reviewed, and the provider would need to have rationale documented for continuing the antipsychotic medication. On 4/25/25 at 1:53 p.m., director of nursing (DON) stated the purpose of an AIMS assessment was to monitor for adverse side effects from antipsychotic medications, and nurses were expected to notify the provider. DON stated it was important to notify the prescribing physician for the safety of the resident. DON verified R46's clinical record lacked evidence the nurse had not notified the physician that R46's AIMS score increased from 0 to 4. DON stated nurses were expected to document in the clinical record to support the physician had been notified. A policy was requested, but not provided by the facility.	2 265		

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2 265	Continued From page 5 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and implement measure to ensure timely notification to the physician. The DON or designee could update policies and procedures, educate staff on these changes, and audit periodically to ensure the needs of resident(s) are maintained. The DON or designee could perform measurable audits and report the findings of those audits to the Quality Assessment and Performance Improvement (QAPI) committee to ensure compliance and determine the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills.	2 302		6/20/25

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2 302	Continued From page 6 (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consumers were provided written or electronic information regarding training staff had received for Alzheimer's/dementia care. This had the potential to affect all 53 current residents, family members, and consumers. Findings include: Review of staff training records verified Alzheimer's Disease and Related Disorders was completed by staff providing care for residents with Alzheimer's/dementia. However, documents lacked evidence consumers were made aware this training had occurred. An email correspondence with director of nursing (DON) dated 4/23/25 at 8:18 a.m., confirmed there was no written or electronic notification provided to the consumers with a description of the dementia training program, categories of employees trained, frequency of the training, or the topics covered. During interview on 4/24/25 at 1:23 p.m., the administrator confirmed there was no written or electronic notification provided to consumers with a description of the dementia training program,	2 302	Corrected	

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2 302	Continued From page 7 the categories of employees trained, the frequency of training, or the basic topics covered. The administrator acknowledged the facility needed to provide consumers with written or electronic information regarding training staff had received for Alzheimer's/dementia care, and it was important to ensure the consumers receive appropriate dementia care. SUGGESTED METHOD OF CORRECTION: The facility could review the Minnesota statutes for dementia training and develop a written or electronic means of communication for the dementia training to the consumer. The facility could implement the communication into their admission process. The facility could then create and implement an auditing system as part of their quality assurance program to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B.	2 570		6/20/25

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2 570	Continued From page 8 This MN Requirement is not met as evidenced by: Based on record review and interviews the facility failed to ensure care conferences were conducted to include input of the resident or resident representatives for 5 of 11 (R10, R19, R20, R21, and R43) residents reviewed for care conferences. Findings include: R10's quarterly Minimum Data Set (MDS) dated 3/14/2025 indicated R10 was severely cognitively impaired and had the following diagnoses: hypertension (HTN) (high blood pressure), arthritis, and Dementia. R10's Care Plan last revised 3/17/25 indicated, R10 had cognitive loss, impaired decision-making skills, and memory deficits. R 10's medical record lacked any documentation the resident, resident representative or family members had been contacted prior to having care conferences for R10 and the implementation of any changes to the care plan. R10's Care Plan Summary dated 3/26/25, indicated input from nursing, social services, and dietary. However, lacked any indication of involvement from resident, resident representative or family members. R19 annual MDS dated 2/21/25, indicated R19 was rarely or never understood, cognition was severely impaired and had the following diagnoses: Dementia, and a seizure disorder. R19's care plan last revised 3/6/25, indicated R19	2 570	Corrected	

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2 570	Continued From page 9 has a diagnosis of dementia, tends to wander and have anxiety when they do not know where they are. R19's care plan also indicated they communicate through their teddy bear, which they feel is alive. R 19's medical record lacked any documentation the resident, resident representative or family members had been contacted prior to having care conferences for R19 and the implementation of any changes to the care plan. R19's Care Plan Summary dated 3/12/25, indicated input from nursing, social services, and dietary. However, lacked any indication of involvement from resident, resident representative or family members. R20 quarterly MDS dated 3/1/25, indicated R20 was severely cognitively impaired and had the following diagnoses: HTN, arthritis, Alzheimer's, hemiparesis or hemiplegia (inability to use one side of one's body), and anxiety. R20's Care plan last revised 3/14/25 indicated R20 has short- and long-term memory issues, impaired decision-making abilities, and required frequent orientation to daily task of living. Also, tended to wander and was unaware of where they were. R 20's medical record lacked any documentation the resident, resident representative or family members had been contacted prior to having care conferences for R20 and the implementation of any changes to the care plan. R20's Care Plan Summary dated 3/25/25, indicated input from nursing, social services, and dietary. However, lacked any indication of	2 570		

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2 570	Continued From page 10 involvement from resident, resident representative or family members. R21's quarterly MDS dated 3/14/25, indicated R21 was severely cognitively impaired and had the following diagnoses: HTN, Alzheimer's, and dementia. R21's Care plan last revised 3/20/25 indicated R21 has a diagnoses of Alzheimer's and dementia, and short-term memory loss. R 21's medical record lacked any documentation the resident, resident representative or family members had been contacted prior to having care conferences for R21 and the implementation of any changes to the care plan. R21's Care Plan Summary dated 3/26/25, indicated input from nursing, social services, and dietary. However, lacked any indication of involvement from resident, resident representative or family members. R43's admission MDS dated 3/4/25, indicated R43 was severely cognitively impaired, and had the following diagnoses: Parkinson's, heart failure (failure of the heart to pump effectively), HTN, and a hip fracture. R43's care plan last revised 3/10/25, indicated severe cognitive impairment, and short-term memory deficits. R 43's medical record lacked any documentation the resident, resident representative or family members had been contacted prior to having care conferences for R43 and the implementation of any changes to the care plan.	2 570		

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2 570	Continued From page 11 R43's Care Plan Summary dated 3/25/25, indicated input from nursing, social services, and dietary. However, lacked any indication of involvement from resident, resident representative or family members. On 4/21/25 at 4:11 p.m., during a phone interview, family member (FM)-G stated they had never been made aware or included in any care conferences or asked to provide any input regarding R21's treatment and services. Furthermore, FM-G stated they would have to like to be included in those discussions. On 4/24/25 during multiple interviews at 12:57 p.m. and 1:51:p.m., social services director (SS)-A stated she was responsible for care conferences. She sent out the care plan summary to the included facility staff to add their input. Once compiled, the staff reviewed it, and SS-A sent it to the family via postal mail for review. Family may or may not request a care conference after review. SS-A stated a cover letter was sent with the care conference summary. If the family did not respond or have questions, no meeting was conducted in the facility. SS-A confirmed she conducted one to one meetings with residents, but it was after the care plan was revised. Further, SS-A stated confused residents may be able to answer yes/no questions, they may not be the best advocate for themselves. On 4/24/25 at 3:44 p.m., the administrator stated their expectation was, care conferences were to be conducted to communicate the needs of the resident, and to update the family of any change in condition, new needs or any new concerns. The administrator stated in the past the facility had had issues with getting family to participate	2 570		

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2 570	Continued From page 12 so they changed their process to sending out the summary after it was completed. The administrator stated they needed a process change to get families more involved in guiding care. The administrator stated the importance of care conferences being conducted with the input of the resident and/or their representative to be sure the residents' cares and needs were met. The facility Person-Centered Care Planning Policy and Procedure last reviewed 1/2025, indicated the care plans will be reviewed at a care planning meeting with the resident and/or representative and a summary shared with the resident/representative. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), social worker (SW) or designee could develop, review, and/or revise policies and procedures to ensure care confereences are scheduled quarterly and family members are invited to attend. The DON, SW or designee could educate all appropriate staff on the policies and procedures. The DON, SW or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program.	21385		6/20/25

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21385	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, and interview the facility failed to conduct appropriate hand hygiene during medication administration for 1 of 3 staff members observed during medication administration. This had the potential to affect at 53 residents in residence at the facility. Findings include: On 4/22/25 at 11:47 a.m., trained medication aide (TMA)-A was observed giving medications to a resident in the main sitting area of the facility. TMA-A then returned to the medication room, where writer was waiting to observe the medication administration. TMA-A agreed to be observed, TMA-A then began preparing medications for a second resident, however, did not perform hand hygiene prior to starting the second medication administration. TMA-A proceeded to administer medications to the second resident, and then returned to the medication cart. TMA-A then began a third resident's medications, and did not perform proper hand hygiene, in between residents. TMA-A then administered the medications to the third resident, came back to the cart, stated they were finished. TMA-A failed to complete hand hygiene after completing all medication administrations. On 4/22/25 at approximately 12:00 p.m., TMA-A requested assistance with another staff member, licensed practical nurse (LPN)-B, who was present in the room during the observation. TMA-A then stated they should have preformed hand hygiene before and after each resident and	21385	Corrected	

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21385	Continued From page 14 in between residents when passing medications. TMA-A confirmed they did not perform hand hygiene appropriately and stated hand hygiene was important to prevent spread of infection. On 4/22/25 at approximately 12:20 p.m., the director of nursing (DON) stated they expected staff members conducting medication administration to perform hand hygiene before and after all medication administrations, and in between residents. The DON stated the importance of completing appropriate hand hygiene to prevent the spread of infection within the facility. The facility's Hand Washing/Hygiene Policy last revised 2/24, indicated hand washing will be completed between resident care and whenever direct physical contact of resident occurs. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure infection control procedures and standards are maintained by all staff as appropriate. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21385		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data	21390		6/20/25

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21390	Continued From page 15 collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure prescribed antibiotics met criteria for antibiotic use. Further, the facility failed to assess for continued need of the antibiotics to help reduce unnecessary antibiotic use and reduce potential drug resistance were completed for 1 of 1 residents (R31) reviewed for antibiotic use. This had the potential to affect any of the 53 residents who resided in the facility who might use antibiotics. Findings include:	21390	Corrected	

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21390	Continued From page 16 R31's quarterly Minimum Data Set (MDS) dated 3/7/25, indicated R31 was cognitively intact, had an indwelling urinary catheter, and diagnoses included Parkinson's disease, dementia, and obstructive uropathy (urine flow is obstructed). R31's order history report, dated 4/25/25, indicated an antibiotic was ordered by the provider for cefpodoxime 200mg twice a day (BID) for a diagnosis of urinary tract infection (UTI), with a start date of 3/29/25 and end date of 4/2/25. R31's progress note, dated 3/26/25 at 3:32 p.m., indicated the licensed practical nurse (LPN)-A notified the provider that R31 completed an order for Macrobid (antibiotic) for a positive UTI, with no improvement in dark, cloudy, odorous urine and increased sleeping. The provider ordered a urinalysis (UA). R31's UA results report, verified 3/28/25, indicated the urine specimen contained "many" bacteria, "500 (large)" leukocytes, ">180 (H)" red blood cells, and "negative" nitrite. On 3/28/25, at the bottom of the UA report, the provider wrote an antibiotic order for cefpodoxime 200 mg by mouth (PO) every (q) 12 hours two times a day (BID). Additionally, the order directed the facility to "update the culture and sensitivity ASAP as it may warrant a change in antibiotic". However, the report did not identify it had been reviewed by a nurse. R31's physician order, dated 3/28/25 at 4:46 p.m., indicated "Start Vantin (cefpodoxime) 200 mg PO q12hrs for 5 days", and "I highly recommend they fax and call with culture and sensitivity results". The order was acknowledged in writing by	21390		

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21390	Continued From page 17 registered nurse (RN)-C. R31's urine culture (UC) results report, verified 3/29/25, indicated "Growth (A) [abnormal] >100,000 CFU/mL mixed bacterial growth" and "Mixed bacterial growth indicates the specimen is likely contaminated at collection with urogenital and/or fecal flora". On 4/1/25, the provider wrote "update with sensitivities", at the bottom of the UC report. However, the report did not identify it had been reviewed by a nurse. R31's clinical record lacked evidence the provider had been notified a "sensitivities" report had not been received. Additionally, R31's clinical record lacked evidence reviewed based on antibiotic stewardship guidelines and criteria. On 4/25/25 at 11:02 a.m., director of nursing (DON) stated she was the facility infection preventionist (IP) and it was her role to oversee the resident infections and antibiotic use. DON stated the facility used McGeer criteria to help identify infections, and Loeb criteria was used to determine when antibiotics were indicated. DON stated R31 had completed taking an antibiotic for a urinary tract infection (UTI) on 3/25/25, but staff reported that R31 was still symptomatic, the provider was notified, and a UA/UC was ordered. DON verified the UC report indicated the sample was likely contaminated and the test had not been repeated. DON confirmed a 72-hour time-out had not been completed. DON stated a 72-hour time-out should have been completed for R31 to identify the provider had not been alerted when UC susceptibilities were not provided. DON stated the antibiotic stewardship guidelines should have been followed to ensure criteria was met and the resident was prescribed the correct antibiotic. DON stated it was important to follow	21390		

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21390	Continued From page 18 the antibiotic stewardship guidelines to avoid antibiotic resistance. The facility's Antimicrobial Stewardship Policy, revised 2/24, indicated the key objectives include reducing inappropriate antimicrobial use, improving patient care outcomes and mitigating adverse consequences. Additionally, the duration of antimicrobial therapy will be defined and/or regularly reviewed based on evidence-based guidelines (ie. 72-hour antibiotic time out). SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review/revise policies and procedures for an antibiotic stewardship program. The director of nursing and/or designee could provide education to staff. The director of nursing and/or designee could audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance	21426		6/20/25

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21426	Continued From page 19 regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure 4 of 6 newly admitted residents (R43, R41, R103, and R205) were screened for tuberculosis (TB) and completed a two-step tuberculosis skin test (TST). Additionally, the facility failed to ensure a TST, IGRA (interferon-gamma release assay blood test) or a chest x-ray was completed for 2 of 6 employees (registered nurse (RN)-A and RN-B) reviewed for TB screening. This had the potential to affect all 53 residents residing in the facility, staff and visitors. Findings include: Center for Disease Control's (CDC) Tuberculin Skin Testing Information for Health Care Providers, dated 9/20, indicated "skin test reaction should be read between 48 and 72 hours after administration". R43's face sheet printed 4/25/25, indicated R43 was admitted to the facility on 2/27/25. R43's medical record lacked a valid step two TST result. R43's Preventative Health Care Report, printed 4/25/25, indicated R43's step two TST was administered on 3/11/25. However, there was no evidence R43's step two TST results were read.	21426	Corrected	

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21426	Continued From page 20 R41's face sheet printed 4/25/25, indicated R41 was admitted to the facility on 3/27/25. R41's medical record lacked a valid step one TST result. R41's Preventative Health Care Report, printed 4/25/25, indicated R41's step one TST was administered on 3/27/25 at 3:01 p.m., and R41's step one TST result was read 3/30/25 at 4:00 p.m. However, R41's step one TST results were read greater than 72 hours after administration. R103's face sheet printed 4/25/25, indicated R103 was admitted to the facility on 4/3/25. R103's medical record lacked a valid step two TST result. R103's Preventative Health Care Report, printed 4/25/25, indicated R103's step two TST was administered on 4/13/25 at 3:30 p.m., and R103's step two TST result was read 4/16/25 at 4:27 p.m. However, R103's step two TST results were read greater than 72 hours after administration. R205's face sheet 4/25/25, indicated R205 was admitted to the facility on 4/9/25. R205's medical record lacked a valid step one TST result. R205's Preventative Health Care Report, printed 4/25/25, indicated R205's step one TST was administered on 4/9/25 at 3:53 p.m., and R205's step one TST result was read 4/12/25 at 6:29 p.m. However, R205's step one TST results were read greater than 72 hours after administration. Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated 7/13, indicated, "An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire."	21426		

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21426	Continued From page 21 RN-A's employee record identified RN-A was hired 12/11/24. RN-A's Baseline TB Screening Tool for Health Care Workers (HCWs) dated 12/11/24, indicated no symptoms of TB and RN-A had not had a TST in the past 12 months. RN-A's employee record included a negative IGRA test result dated 7/12/23. However, the negative IGRA test results were dated greater than 90 days before hire. RN-B employee record identified RN-B was hired 3/19/25. RN-B's Baseline TB Screening Tool for HCWs dated 3/19/25, indicated no symptoms of TB and RN-B had not had a TST in the past 12 months. RN-B's employee record included a negative T-spot TB test result dated 4/5/23. However, the negative TB test results were dated greater than 90 days before hire. On 4/25/25 at 10:45 a.m., director of nursing stated resident TB testing criteria included a two-step TST with results read within 48 and 72 hours after administration. DON acknowledged the TST results for R41, R43, R103, and R205, were not read between 48 and 72 hours after administration, as per CDC guidelines. DON confirmed RN-A's TB blood test was dated 7/12/23 and was greater than 90 days before hire. DON confirmed RN-B's TB blood test was dated 4/5/23 and was greater than 90 days before hire. DON stated RN-A and RN-B would not return to work until they had a negative TB blood test or negative step one TST. Additionally, DON stated TB testing was important to ensure no one has active TB and prevent the spread of TB to others. DON stated TB testing needed to be completed before staff started working with residents. The facility's Tuberculosis Infection Control	21426		

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21426	Continued From page 22 Program Policy for residents, reviewed 8/2016, indicated documentation of resident TB screening within 72 hours of admission or within 3 months prior to admission included two-step skin testing, and results were kept in the resident chart. The facility's Employee Tuberculosis Program Policy, reviewed 8/2016, indicated employees must have a baseline Mantoux test within 3 months prior to employment or at time of employment. However, the facility's policy lacks information pertaining to IGRA and chest x-ray. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review tuberculosis policies and procedures to ensure compliance. The director of nursing (DON) or designee could review the assessment process for residents and staff to be sure the documentation of the TB tests are completed per guidelines. The director of nursing or designee could monitor compliance for screening and TB testing for residents and staff. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is	21530		6/20/25

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21530	Continued From page 23 available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consulting pharmacist (PharmD) identified the facility's lack of target behavior monitoring in the monthly medication regimen review (MRR) for 1 of 5 residents (R46) reviewed for unnecessary psychotropic medications.	21530	Corrected	

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21530	Continued From page 24 Findings include: R46's quarterly Minimum Data Set (MDS) dated 4/16/25, indicated R46 admitted to the facility on 11/15/24, had severe cognitive impairment, and diagnoses included Alzheimer's disease, delusional disorders, and anxiety disorder. R46's order summary, printed 4/25/25, indicated R46 had the following psychotropic medication orders: - paroxetine (antidepressant) 40 mg daily for panic disorder - quetiapine 50 mg BID for delusional disorders R46's November 2024 Target Behavior Monitoring log identified target behaviors anxiety, agitation, feeling down, depressed, and hopeless, and the log indicated target behaviors were monitored 8 of 45 shifts. Additionally, R46's clinical record lacked evidence of documented target behavior monitoring from 12/1/24 through 4/22/25. R46's progress note, dated 04/07/25 at 6:11 a.m., indicated medications were reviewed by PharmD, and no problems identified. However, the MRR failed to identify the facility's lack of target behavior monitoring for R46's psychotropic medication use. R46's progress note, dated 03/09/25 at 10:23 a.m., indicated medications were reviewed by PharmD, and a gradual dose reduction (GDR) was recommended as follows: 1. Please evaluate and document ongoing need for paroxetine for anxiety and quetiapine for delusions. Document target behaviors and symptoms being controlled. Consider attempting	21530		

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21530	Continued From page 25 dose reduction if appropriate. However, the MRR failed to identify the facility's lack of target behavior monitoring for R46's psychotropic medication use. R46's progress note, dated 02/02/25 at 09:10 a.m., indicated medications were reviewed by PharmD, and no problems identified. However, the MRR failed to identify the facility's lack of target behavior monitoring for R46's psychotropic medication use. R46's progress note, dated 1/6/25 at 9:47 a.m., indicated medications were reviewed by PharmD, and the following recommendations were made: 1. Recommend monitoring orthostatic blood pressure monthly while on Seroquel. If unable to obtain orthostatic blood pressure, please document reason. Recommend entering order into matrix for monthly orthostatic blood pressures. 2. Patient is noted to have multiple falls recently. Paxil and Seroquel may contribute. Seroquel dose has been increased twice in the last month. Determine if medications are contributing to falls and if benefits outweigh risks of medications. 3. Recent lipid panel showed elevated triglycerides, LDL, and total cholesterol. Consider adding lipid lowering medication such as atorvastatin. However, the MRR failed to identify the facility's lack of target behavior monitoring for R46's psychotropic medication use. R46's progress note, dated 1/6/25 at 9:47 a.m., indicated medications were reviewed by PharmD, and to review report for recommendations. However, the MRR failed to identify the facility's lack of target behavior monitoring for R46's psychotropic medication use.	21530		

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21530	Continued From page 26 On 4/25/25 at 12:25 p.m., consulting pharmacist (PharmD) stated every psychotropic medication needed identified target behaviors. Staff are expected to monitor the identified target behaviors, and the monitoring should be documented so the provider can identify if behaviors have increased. On 4/25/25 at 1:53 p.m., director of nursing (DON) verified R46's clinical record lacked evidence of target behavior monitoring from 12/1/24 through 4/22/25. DON stated nurses were expected to initiate target behavior monitoring when the provider ordered a psychotropic medication. DON stated target behavior monitoring was necessary, so providers know if a psychotropic medication has been effective/ineffective and if target behaviors have increased/decreased. DON stated the target behavior monitoring is important so providers can determine if a psychotropic medication is appropriate. The facility's Pharmacy Consultant Expectations Policy, revised 2/24, indicated to meet the needs of each resident accurately and safely, by collaborating with the licensed pharmacist, serving as consultant, to guide the facility with a system consistent with clinical best practice, quality resident care, and regulatory compliance for pharmacy services in the facility. Additionally, the consulting pharmacist would conduct monthly medication regimen review (MRR) for each resident to address irregularities. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy reviews and irregularities. The director	21530		

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21530	Continued From page 27 of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure pharmacy reviews are timely and irregularities are identified. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced	21535		6/20/25

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21535	Continued From page 28 by: Based on interview and document review, the facility failed to ensure target behaviors were consistently monitored for 5 of 5 residents (R7, R28, R30, R46, R1) reviewed for unnecessary psychotropic medication use. Findings include: R7's quarterly Minimum Data Set (MDS), dated 3/14/25, indicated R7 admitted to the facility on 3/9/22, had severe cognitive impairment, and diagnoses included dementia, delusional disorders, and depression. R7's order summary, printed 4/25/25, indicated R7 had the following psychotropic medication orders: lorazepam concentrate (antianxiety) 0.25 mL (0.5 mg) twice a day (BID) for anxiety disorder quetiapine (antipsychotic) 25 mg daily for dementia with other behavioral disturbance Sertraline (antidepressant) 100 mg daily for dementia with other behavioral disturbance R7's target behavior monitoring lacked consistent monitoring for the identified target behaviors anxiety, agitation, and delusions. R7's Target Behavior Monitoring logs from 10/1/24 through 4/20/25, indicated the following: April 2025 - 44 of 60 shifts documented March 2025 - 48 of 93 shifts documented February 2025 - 44 of 84 shifts documented January 2025 - 39 of 93 shifts documented December 2024 - 44 of 93 shifts documented November 2024 - 48 of 93 shifts documented October 2024 - 52 of 93 shifts documented	21535	Corrected	

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21535	Continued From page 29 R28's annual MDS, dated 2/21/25, indicated R28 had severe cognitive impairment, and diagnoses including dementia, and depression. R28's order summary printed 4/25/25, indicated R28 had the following psychotropic medication orders: Olanzapine (antipsychotic) 2.5 mg orally (by mouth) at bedtime for auditory hallucinations. Sertraline (antidepressant) 100 mg daily for major depressive disorder. Zoloft (Sertraline- trade name of drug above) (antidepressant) 50 mg daily for total dose of 150 mg daily, for major depressive disorder. R28's target behavior monitoring lacked consistent monitoring for the identified target behaviors feeling down, depressed or hopeless, insomnia, and auditory hallucinations. R28's Target Behavior Monitoring Logs from 10/1/24 through 4/20/25 indicated the following: April 2025: 47 of 60 shifts documented. March 2025: 44 of 93 shifts documented. February 2025: 36 of 84 shifts documented. January 2025: 48 of 93 shifts documented. December 2024: 52 of 93 shifts documented. November 2024: 57 of 90 shifts documented. October 2024: 37 of 93 shifts documented. R30's quarterly Minimum Data Set (MDS), dated 3/14/25, indicated R30 admitted to the facility on 3/24/22, had severe cognitive impairment, and diagnoses included dementia and anxiety disorder. R30's order summary, printed 4/25/25, indicated R30 had the following psychotropic medication orders:	21535		

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21535	Continued From page 30 lorazepam 0.5 mg three times a day (TID) for anxiety disorder olanzapine (antipsychotic) 5 mg BID for delusions due to Korsakoff syndrome (neuropsychiatric condition affecting memory) R30's target behavior monitoring lacked consistent monitoring for the identified target behaviors anxiety and distressing delusions. R30's Target Behavior Monitoring logs from 10/1/24 through 4/20/25, indicated the following: April 2025 - 39 of 60 shifts documented March 2025 - 39 of 93 shifts documented February 2025 - 45 of 84 shifts documented January 2025 - 39 of 93 shifts documented December 2024 - 45 of 93 shifts documented November 2024 - 48 of 93 shifts documented October 2024 - 53 of 93 shifts documented R46's quarterly Minimum Data Set (MDS) dated 4/16/25, indicated R46 admitted to the facility on 11/15/24, had severe cognitive impairment, and diagnoses included Alzheimer's disease, delusional disorders, and anxiety disorder. R46's order summary, printed 4/25/25, indicated R46 had the following psychotropic medication orders: paroxetine (antidepressant) 40 mg daily for panic disorder quetiapine 50 mg BID for delusional disorders R46's target behavior monitoring lacked consistent monitoring for the identified target behaviors anxiety, agitation, feeling down, depressed, and hopeless. R46's Target Behavior Monitoring logs from 11/15/24 through 4/20/25,	21535		

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21535	Continued From page 31 indicated the following: April 2025 - no evidence of documented target behavior monitoring found in clinical record March 2025 - no evidence of documented target behavior monitoring found in clinical record February 2025 - no evidence of documented target behavior monitoring found in clinical record January 2025 - no evidence of documented target behavior monitoring found in clinical record December 2024 - no evidence of documented target behavior monitoring found in clinical record November 2024 - 8 of 45 shifts documented R1 quarterly minimum data set (MDS) dated 12/13/24 indicated R1 was admitted to the facility on 5/1/2018, was cognitively impaired and had the following diagnoses: anxiety, bipolar disease and schizophrenia (a chronic mental disorder characterized by symptoms such as hallucinations, delusions and cognitive challenges). R1's order summary printed 4/25/25 indicated R1 took following medications: Depakote ER 1000 mg once daily for Schizophrenia, Ziprasidone 80 mg twice daily for Schizophrenia, Seroquel 100 mg twice daily for Schizophrenia, and Wellbutrin XL 300 mg once daily for bipolar disorder. The order summary also indicated an order to monitor affect/alertness, increased delusions that are distressing to resident and unable to manage with staff interventions; update primary care provider for worsening symptoms. Review of R1's Target Behavior monitoring for January 2025 through April 2025 lacked consistent monitoring for distressing delusions, hallucinations, and increased anxiety with many days left blank with no documentation of	21535		

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21535	Continued From page 32 monitoring taking place. On 4/25/25 at 12:25 p.m., consulting pharmacist (PharmD) stated every psychotropic medication needed identified target behaviors. Staff were expected to monitor the identified target behaviors. The monitoring needed to be documented so the provider can identify if behaviors had increased. On 4/25/25 at 1:53 p.m., director of nursing (DON) stated staff were expected to document for target behaviors every shift. The DON stated she was aware there were "holes in the monitoring, and verified the target behavior monitoring documentation was not maintained appropriately for R7, R28, R30, R46 and R1. DON stated target behavior monitoring was necessary, so providers know if a psychotropic medication had been effective/ineffective and if target behaviors had increased/decreased. DON stated the target behavior monitoring was important so providers can determine if a psychotropic medication was appropriate. The facility's Psychotropic Target Behavior Monitoring Policy, last reviewed 6/23, indicated target behavior monitoring would be initiated with the use of antipsychotic/neuroleptic medications to meet state/federal/pharmacy behavior monitoring guidelines/recommendations. Additionally, the MDS nurse would tally results at the end of each month. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and the consulting pharmacist could develop and/or revise policies to monitor medications for adequate monitoring to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being and be consistent	21535		

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21535	Continued From page 33 with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review articles that are published in medical and/or pharmacy journals. Audits could be developed to monitor medications for adequate monitoring. The DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further education. TIME PERIOD FOR CORRECTION: 21 DAYS	21535		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the	21830		6/20/25

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21830	Continued From page 34 family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family	21830		

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21830	Continued From page 35 members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on record review and interviews the facility failed to ensure care conferences were conducted to include input of the resident or resident representatives for 5 of 11 (R10, R19, R20, R21, and R43) residents reviewed for care conferences. Findings include: R10's quarterly Minimum Data Set (MDS) dated 3/14/2025 indicated R10 was severely cognitively impaired and had the following diagnoses: hypertension (HTN) (high blood pressure),	21830	Corrected	

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21830	Continued From page 36 arthritis, and Dementia. R10's Care Plan last revised 3/17/25 indicated, R10 had cognitive loss, impaired decision-making skills, and memory deficits. R 10's medical record lacked any documentation the resident, resident representative or family members had been contacted prior to having care conferences for R10 and the implementation of any changes to the care plan. R10's Care Plan Summary dated 3/26/25, indicated input from nursing, social services, and dietary. However, lacked any indication of involvement from resident, resident representative or family members. R19 annual MDS dated 2/21/25, indicated R19 was rarely or never understood, cognition was severely impaired and had the following diagnoses: Dementia, and a seizure disorder. R19's care plan last revised 3/6/25, indicated R19 has a diagnosis of dementia, tends to wander and have anxiety when they do not know where they are. R19's care plan also indicated they communicate through their teddy bear, which they feel is alive. R 19's medical record lacked any documentation the resident, resident representative or family members had been contacted prior to having care conferences for R19 and the implementation of any changes to the care plan. R19's Care Plan Summary dated 3/12/25, indicated input from nursing, social services, and dietary. However, lacked any indication of involvement from resident, resident	21830		

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21830	Continued From page 37 representative or family members. R20 quarterly MDS dated 3/1/25, indicated R20 was severely cognitively impaired and had the following diagnoses: HTN, arthritis, Alzheimer's, hemiparesis or hemiplegia (inability to use one side of one's body), and anxiety. R20's Care plan last revised 3/14/25 indicated R20 has short- and long-term memory issues, impaired decision-making abilities, and required frequent orientation to daily task of living. Also, tended to wander and was unaware of where they were. R 20's medical record lacked any documentation the resident, resident representative or family members had been contacted prior to having care conferences for R20 and the implementation of any changes to the care plan. R20's Care Plan Summary dated 3/25/25, indicated input from nursing, social services, and dietary. However, lacked any indication of involvement from resident, resident representative or family members. R21's quarterly MDS dated 3/14/25, indicated R21 was severely cognitively impaired and had the following diagnoses: HTN, Alzheimer's, and dementia. R21's Care plan last revised 3/20/25 indicated R21 has a diagnoses of Alzheimer's and dementia, and short-term memory loss. R 21's medical record lacked any documentation the resident, resident representative or family members had been contacted prior to having care conferences for R21 and the implementation	21830		

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21830	Continued From page 38 of any changes to the care plan. R21's Care Plan Summary dated 3/26/25, indicated input from nursing, social services, and dietary. However, lacked any indication of involvement from resident, resident representative or family members. R43's admission MDS dated 3/4/25, indicated R43 was severely cognitively impaired, and had the following diagnoses: Parkinson's, heart failure (failure of the heart to pump effectively), HTN, and a hip fracture. R43's care plan last revised 3/10/25, indicated severe cognitive impairment, and short-term memory deficits. R 43's medical record lacked any documentation the resident, resident representative or family members had been contacted prior to having care conferences for R43 and the implementation of any changes to the care plan. R43's Care Plan Summary dated 3/25/25, indicated input from nursing, social services, and dietary. However, lacked any indication of involvement from resident, resident representative or family members. On 4/21/25 at 4:11 p.m., during a phone interview, family member (FM)-G stated they had never been made aware or included in any care conferences or asked to provide any input regarding R21's treatment and services. Furthermore, FM-G stated they would have to like to be included in those discussions. On 4/24/25 during multiple interviews at 12:57 p.m. and 1:51:p.m., social services director	21830		

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21830	Continued From page 39 (SS)-A stated she was responsible for care conferences. She sent out the care plan summary to the included facility staff to add their input. Once compiled, the staff reviewed it, and SS-A sent it to the family via postal mail for review. Family may or may not request a care conference after review. SS-A stated a cover letter was sent with the care conference summary. If the family did not respond or have questions, no meeting was conducted in the facility. SS-A confirmed she conducted one to one meetings with residents, but it was after the care plan was revised. Further, SS-A stated confused residents may be able to answer yes/no questions, they may not be the best advocate for themselves. On 4/24/25 at 3:44 p.m., the administrator stated their expectation was, care conferences were to be conducted to communicate the needs of the resident, and to update the family of any change in condition, new needs or any new concerns. The administrator stated in the past the facility had had issues with getting family to participate so they changed their process to sending out the summary after it was completed. The administrator stated they needed a process change to get families more involved in guiding care. The administrator stated the importance of care conferences being conducted with the input of the resident and/or their representative to be sure the residents' cares and needs were met. The facility Person-Centered Care Planning Policy and Procedure last reviewed 1/2025, indicated the care plans will be reviewed at a care planning meeting with the resident and/or representative and a summary shared with the resident/representative.	21830		

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21830	Continued From page 40 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), social worker (SW) or designee could develop, review, and/or revise policies and procedures to ensure care confereences are scheduled quarterly and family members are invited to attend. The DON, SW or designee could educate all appropriate staff on the policies and procedures. The DON, SW or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		
21840	MN St. Statute 144.651 Subd. 12 Patients & Residents of HC Fac.Bill of Rights Subd. 12. Right to refuse care. Competent residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the resident's medical record. This MN Requirement is not met as evidenced by: Based on interview, and document review the facility failed to ensure advanced directives for emergency treatment were accurately reflected in all areas of the medical record to ensure the	21840	Corrected	6/20/25

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21840	Continued From page 41 residents wishes would be implemented correctly in an emergent situation for 1 of 1 (R45) residents reviewed for inconsistent advanced directives. Findings include: R45's quarterly Minimum Data Set (MDS) dated 2/7/25, indicated R45 was admitted on 8/5/2024, was cognitively intact, and had the following diagnoses: Hyperlipidemia (high fat levels in the blood), and Schizophrenia. R45's untitled code status form dated 8/5/2024, indicated R45's resuscitation wishes were "Do Not Resuscitate". The Document was signed by R45, their family member, and the physician. R45's physician orders reviewed and saved on 4/21/25 at 6:01 p.m., indicated R45 was FULL CODE. On 4/21/25 at 6:02 p.m., trained medical assistant (TMA)-B stated they would refer to the resident's hard chart when the needed to know their code status. TMA-B went to charting room and visually pointed out R45's code status was DNR on their hard chart, which would have been correct. On 4/21/25 at 6:05 p.m., registered nurse (RN)-A stated when needed to confirm a resident's code status they would use the hard chart or the face sheet. RN-A confirmed R45 was a DNR. RN-A stated the provider would typically go over the code status with a resident and then it would be entered into the charting system. On 4/21/25 at 6:09 p.m., the director of nursing (DON) stated their expectation for checking code statuses was employees will check the resident's	21840		

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21840	Continued From page 42 hard chart in the report room, where the code statuses are on the side of the book, in their medical administration record (MAR), or on the matrix banner. Typically, social services will go over code statuses with residents, and then a record keeper will enter the order once it is signed. DON stated RN's will typically review the code status order prior to it being entered into the electronic medical record (EMR) but stated it was not always happening. The DON reviewed R45's chart and EMR and stated R45 was a DNR, the DON then reviewed the physician orders and confirmed R45's was listed as a FULL CODE and not a DNR as per R45's wishes. The DON confirmed all areas in the chart should match to fulfill the resident wishes. The facility's Cardiopulmonary Resuscitation (CPR) policy last reviewed 1/2025, indicated they provided basic life support, including CPR-Cardiopulmonary Resuscitation, when a resident required such emergency care, subject to physician order and resident choice indicated in the resident's advance directives. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures for advanced directives, physician orders and/or a POLST to ensure records are consistent and accurate throughout the medical record upon admission, quarterly, and with any significant change such as the election of a hospice benefit. The DON could also ensure a process for inputting changed data appropriately into the electronic medical record. Staff could be educated on the need to clarify discrepancies in advanced directives, POLST, and/or physician orders. The DON or designee could review the resident affected, and all other current residents to ensure accuracy of code	21840		

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21840	Continued From page 43 status and audit any newly admitted resident EMR. The results of those audits could be reviewed by the Quality Assurance Performance Improvement (QAPI) to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21840		

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 **01 - MAIN BUILDING 01** B. WING _____	**04/23/2025**

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K 000	INITIAL COMMENTS An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/23/2025. At the time of this survey, COKATO MANOR was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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 REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/23/2025

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 1 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. COKATO MANOR was constructed at five different times. A one-story building with a partial basement was constructed in 1964 and determined to be Type II (000). Additions were added in 1984, 1994, 1999, and 2006. The 1999 addition included a Physical Therapy Area. The Assisted Living facility is separated from the Physical Therapy Area portion of the addition by a 2-hour fire-rated building separation wall. Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed	K 000		

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K 000	Continued From page 2 as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors that is monitored for automatic fire department notification. Smoke detectors located in the resident room report to a Nurse Call system that is monitored at the Nurses Station. The facility has a capacity of 56 beds and had a census of 53 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/23/2025 between 09:30 AM and 12:00 PM,	K 291	Deficiency: Documentation that the emergency lighting in the facility had not had a 90-minutes annual test completed within the last 12 months. Tag Number: K291 Regulation: Emergency Lighting CFR(s): NFPA 101 Requirement: Emergency lighting shall be provided of at least 90 minute duration is provided automatically in accordance with	5/22/25

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K 291	Continued From page 3 it was revealed by a review of available documentation that the emergency lighting in the facility had not had a 90-minute annual test completed within the last 12 months. An interview with the Administrator and the Maintenance Director verified this deficient finding at the time of discovery.	K 291	NFPA 101 ¿ 7.9 and related codes, ensuring illumination is available for exits and critical areas in the event of a power failure. _____ 1. Corrective Action Taken for Residents Found to be Affected All emergency lighting units (including battery-backed fixtures and generator-powered circuits) were inspected, and any inoperative or malfunctioning units were immediately repaired or replaced. This ensured that all egress paths and critical areas (e.g., nurse stations, medication rooms) are compliant with lighting requirements during power outages. _____ 2. Identification of Other Residents Who Could Be Affected A full facility audit was conducted to identify any other areas or residents who might be affected by inadequate emergency lighting. All resident care areas, corridors, exit pathways, and common areas were included in this inspection to ensure facility-wide compliance. _____ 3. Measures to Ensure the Deficient Practice Does Not Recur " A Preventative Maintenance Program has been implemented: o Monthly testing of all emergency lights (including 30-second functional test). o Annual 90-minute full-load test of	

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K 291	Continued From page 4	K 291	battery-powered and generator-backed systems. " Documentation logs have been established to record test dates, results, and any corrective actions. " Staff training on emergency lighting response and reporting of outages was completed on 5/19/2025. " Facility engineer or maintenance supervisor will oversee compliance with ongoing checks and tests. _____ 4. Monitoring to Ensure Ongoing Compliance " The Maintenance Director or designee will review emergency lighting logs monthly for the next 6 months. " Results will be reported to the Safety Committee and Quality Assurance & Performance Improvement (QAPI) Committee. " Any failure to meet standards will trigger an immediate corrective response and retraining, if necessary. _____ 5. Completion Date for Corrective Action: 5/22/2025	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire	K 353		5/22/25

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K 353	Continued From page 5 Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1.2 (1) and (5). These deficient findings could have a patterned impact on residents within the facility. Findings include: 1. On 04/23/2025 between 9:30 AM and 12:00 PM, it was revealed by observation that sprinkler heads in the main kitchen along the cook line, and in the laundry area above the dryer were covered in a layer of lint and debris. 2. On 04/23/2025 between 9:30 AM and 12:00 PM, it was revealed by observation that a sprinkler head in the laundry area was showing signs of leaking.	K 353	Deficiency: Facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Sprinkler heads in the main kitchen along cookline and in laundry were coved in a layer of lint and debris. Sprinkler head in the laundry area showing signs of leaking. Tag Number: K353 Regulation: Sprinkler System Maintenance and Testing CFR(s): NFPA 101 Requirement: NFPA 101: The sprinkler system must be tested and maintained in accordance with NFPA 25. Facilities must ensure annual inspections, quarterly flow tests, and maintenance of sprinkler systems are conducted and documented. _____ _____	

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K 353	Continued From page 6 An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	1. Corrective Action Taken for Residents Found to be Affected All residents in the affected area were assessed, and no negative outcomes related to fire protection or sprinkler system failure were identified. The facility immediately contacted a licensed fire protection contractor to complete overdue testing and inspection of the sprinkler system. Date Completed: 5/19/2025 _____ 2. Identification of Other Residents at Risk and Action Taken A full audit of all facility areas was conducted to ensure sprinkler coverage is functional and up to date. No additional areas were found to be out of compliance. _____ 3. Measures and Systemic Changes to Prevent Recurrence " The facility has contracted with a licensed fire protection company to perform all required quarterly, semi-annual, and annual sprinkler testing and inspections. " A tracking system has been implemented using a digital calendar and compliance log to monitor due dates for all required fire protection inspections. " The Maintenance Director has been trained on NFPA 25 requirements regarding sprinkler testing intervals and documentation. _____ 4. Monitoring to Ensure Ongoing	

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K 353	Continued From page 7	K 353	Compliance " The Administrator or designee will review the sprinkler system inspection log monthly for the next 6 months. " Results will be reported monthly to the Quality Assurance and Performance Improvement (QAPI) Committee. " Any identified issues will be addressed immediately, and corrective actions will be taken. _____ 5. Completion Date: 5/22/2025	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.11, and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility.	K 521	Deficiency: Documentation that the facility could not provide a current fire damper inspection report for an inspection that would have occurred in the last 4 years. Tag Number: K521 Regulation: HVAC CFR(s): NFPA 101 Requirement: HVAC CFR(S): NFPA 101; HVAC Heating, ventilation, and air	5/22/25

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K 521	Continued From page 8 Findings include: On 04/23/2025, between 9:30 AM and 12:00 PM, it was revealed by a review of available documentation that the facility could not provide a current fire damper inspection report for an inspection that would have occurred in the last 4 years. An interview with the Administrator and Maintenance Director verified this deficient finding at the time of discovery.	K 521	conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturers specifications. 18.5.2.1, 19.5.2.1, 9.2 1. Corrective Action Taken for Residents Affected Upon review of maintenance records the smoke dampers were inspected; however, it was not documented correctly. 2. Measures to Ensure It Does Not Recur " Full facility inspection of all HVAC ducts, dampers, and wall penetrations have been contracted with an outside company A R Engh Heating & Air Conditioning who will complete all inspections. " Preventive maintenance procedures were reviewed and updated. 3. Systemic Changes Implemented " A quarterly inspection checklist has been developed for dampers and duct penetrations. " Maintenance staff were trained on HVAC system safety requirements, NFPA 90A, and firestop techniques on 5/19/2025. " The facility's Life Safety Compliance Officer will perform monthly checks on a rotating schedule. 4. Monitoring to Ensure Sustained	

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K 521	Continued From page 9	K 521	Compliance " Facility Maintenance Supervisor will conduct monthly HVAC compliance audits for 6 months. " Results will be reviewed at the QAPI meeting monthly. " Any deficiencies found will be corrected within 24 hours and reported. _____ 5. Completion Date 5/22/2025	
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code sections 19.7.1.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 712	Deficiency: Fire Drills did not comply with NFPA 90A requirements (e.g., Conducting fire drills per NFPA 101 (2012 edition), Life Safety Code Sections 19.7.1.4 through 19.7.1.7). Facility had not been verifying transmission of the fire alarm to the monitoring company as part of the Fire Drill Report. Tag Number: K712	5/22/25

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K 712	Continued From page 10 On 04/23/2025 between 9:30 AM and 12:00 PM, it was revealed by a review of available documentation that the facility had not been verifying transmission of the fire alarm to the monitoring company as part of the Fire Drill Report. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	Regulation: Fire Drills CFR(s): NFPA 101 Requirement: Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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 per NFPA 101 (2012 edition), Life Safety Code Sections 19.7.1.4 through 19.7.1.7). _____ 1. Corrective Action Taken for Those Found to Be Affected: All staff were immediately re-educated on the fire drill procedures and requirements. A review of fire drill documentation for the past 12 months was conducted to ensure compliance. Any missing or incomplete documentation was addressed and corrected to the greatest extent possible. _____ 2. Identification of Other Residents/Staff at Risk: A full audit of fire drill logs for the past year was completed to ensure drills were conducted across all shifts (day, evening, night) on a quarterly basis as required. Staff who had not participated in a drill within the required timeframe were identified. _____ 3. Systemic Changes Implemented: " A Fire Drill Schedule has been created for the next 12 months, ensuring	

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K 712	Continued From page 11	K 712	quarterly drills are conducted on all three shifts. " The Maintenance Director or Designee will be responsible for coordinating and documenting all fire drills. " A Fire Drill Log Template has been updated to include: o Date and time of drill o Shift o Type of drill (announced/unannounced) o Departments involved o Observations and corrective actions o Signature of the drill supervisor " All nursing and ancillary staff received in-service training on fire drill expectations and procedures. " All new employees will receive fire safety training as part of orientation. _____ 4. Monitoring and Quality Assurance: " The Safety Committee will review fire drill logs monthly for completeness and compliance. " The Administrator or designee will audit fire drill documentation quarterly and report findings to the QAPI Committee. " Any deficiencies will result in re-training and follow-up drills as necessary. _____ 5. Date of Compliance: All corrective actions will be completed by: 5/22/2025	
K 914 SS=F	Electrical Systems - Maintenance and Testing	K 914		5/22/25

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K 914	Continued From page 12 CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2 , 6.3.4.1.3, and 6.3.4.2.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/23/2025 between 9:30 AM and 12:00 PM, it was revealed by a review of available	K 914	Deficiency: At the time of the survey facility did not have documentation showing that electrical receptacle testing had taken place within the last 12 months. Tag Number: K914 Regulation: Electrical Systems Maintenance and Testing CFR(s): NFPA 101 Requirement: Electrical system components were found to be noncompliant with NFPA 70/99 requirements, specifically [e.g., maintain records of required testing, repairs or	

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

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K 914	Continued From page 13 documentation that at the time of the survey the facility did not have documentation showing that electrical receptacle testing had taken place within the last 12 months. An interview with the Administrator and Maintenance Director verified this deficient finding at the time of discovery.	K 914	modifications containing date, room or area tested and results]. _____ Corrective Action Steps 1. Immediate Correction: o All deficient electrical components (e.g., broken outlets, ungrounded receptacles, open junction boxes) were immediately taken out of service upon identification. o Temporary signage and barriers were put implemented to ensure resident and staff safety. o A licensed electrician was contracted on 5/19/2025 to correct all deficiencies. 2. Systemic Changes: o A full audit of the facility's electrical systems was completed by a licensed electrical contractor on 5/19/2025. o Based on findings, a prioritized repair schedule was created. o High-risk areas (patient care zones, emergency circuits) were addressed first. 3. Staff Training: o Maintenance and engineering staff were retrained on electrical safety protocols and NFPA 70/99 standards on 5/19/2025. o A policy was reinforced requiring immediate reporting of any observed electrical hazards. 4. Preventive Maintenance Implementation: o The facility updated its Preventive Maintenance Plan to include: ¿ Quarterly electrical inspections of high-use areas.	

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K 914	Continued From page 14	K 914	¿ Annual inspection of the entire electrical infrastructure. ¿ Documentation of all repairs and inspections. o Maintenance team to use a new electrical inspection checklist compliant with NFPA codes. _____ _____ Date of Compliance: All corrective actions will be completed by: 5/22/2025	
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the	K 918		5/22/25

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K 918	Continued From page 15 components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.3.4, 8.4.1, and 8.4.2.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/23/2025 between 9:30 AM and 12:00 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that monthly generator operational inspection and testing had occurred from August to December 2024. An interview with the Administrator and Maintenance Director verified this deficient finding at the time of discovery.	K 918	Deficiency: The facilitys essential electrical system (e.g., emergency power systems, emergency lighting, etc.) is not in full compliance with the applicable regulations (facility could not provide documentation showing monthly generator operational inspection and testing had occurred from August to December 2024). Tag Number: K918 Regulation: Electrical Systems Essential Electric System CFR(s): NFPA 101 Requirement: The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10 second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 2040-day intervals, and exercised once every 36	

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K 918	Continued From page 16	K 918	months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel Per NFPA 111. _____ Root Cause Analysis: The deficiency was caused by lack of maintaining documentation of testing. This may include: " Improper maintenance of the emergency power system. " Lack of regular testing or inspection of emergency lights or generators. " Failure to meet current codes due to changes in regulations that were not updated in the system. " Staff training gaps leading to inadequate response during testing and maintenance procedures. _____ Immediate Actions Taken: 1. Inspection and Testing: o Completed a full inspection of the essential electrical system, including emergency lighting, power generators, and alarms, by a certified technician. o Identified and repaired any deficiencies such as faulty connections, outdated equipment, or non-functional emergency lighting. 2. Corrective Actions: o Implement a comprehensive and proactive maintenance program that includes: ¿ Weekly visual inspection of	

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K 918	Continued From page 17	K 918	generators to be completed by designated maintenance personnel ¿ Monthly testing of emergency lighting and backup power systems. ¿ Quarterly inspections of the electrical panel, wiring, and emergency alarms. ¿ Annual full-system review by an external certified technician. 3. Training and Education: o Schedule a training session for all maintenance staff on the importance of K918 compliance and how to identify potential failures in the system. o Include routine drills and procedures on how to respond during electrical failures, including when backup systems must be engaged. 4. Equipment Upgrades (if applicable): o Replace outdated equipment or upgrade to systems that comply with the most current codes and standards. o Install a monitoring system that provides real-time alerts to the facilitys management team if the essential electrical system experiences any faults or failures. _____ Completion Date: " Date for Immediate Actions Completion: 5/22/2025 _____ Monitoring and Verification: " Ongoing Inspections: The essential electrical system will undergo regular audits and compliance checks by the facilitys Safety Officer and external contractors every month.	

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K 918	Continued From page 18	K 918	" Documentation: All inspection reports, training logs, and maintenance records will be kept up to date and readily available for review during follow-up surveys or inspections.	
K 926 SS=E	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement medical gas training for staff per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/23/2025 between 9:00 AM and 12:00 PM, it was revealed by review of available documentation that the facility was unable to provide documentation showing that training for personnel concerned with the application and maintenance of medical gases and those who handle medical gases are receiving continuing education for the safety guidelines and usage	K 926	Deficiency: At the time of survey the facility was unable to provide documentation showing that training for personnel concerned with the application and maintenance of medical gases and those who handle medical gases are receiving continuing education for the safety guidelines and usage requirements for medical gases and their cylinders. Tag Number: K926 Regulation: Gas Equipment Qualification and Training CFR(s): NFPA 101 Requirement: Gas equipment - qualifications and training of personnel. Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing	5/22/25

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K 926	Continued From page 19 requirements for medical gases and their cylinders. An interview with the Administrator and Maintenance Director verified this deficient finding at the time of discovery.	K 926	education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment per NFPA 99 A. Statement of Deficiency The facility was found to be non-compliant with K926 due to improper handling, storage, or maintenance of medical gases as per [regulation or guideline reference, e.g., NFPA 99]. B. Immediate Actions Taken 1. Inspection of Medical Gas Systems: A comprehensive inspection of all medical gas systems was conducted by a licensed professional to identify any hazards or deficiencies. 2. Secured Medical Gas Cylinders: All medical gas cylinders were properly secured in accordance with the facilitys policies and relevant codes (NFPA 99, OSHA). Any unsecured cylinders were immediately addressed and repositioned. 3. Labeling and Signage: Proper labeling of medical gas tanks and appropriate warning signs (e.g., "Flammable Gas," "Oxygen No Smoking") were ensured to be clearly visible in the medical gas storage area. 4. Immediate Staff Education: All staff responsible for the management and operation of medical gases were immediately educated on the correct protocols for handling, storing, and using medical gases.	

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K 926	Continued From page 20	K 926	_____ C. Corrective Actions 1. Re-training of Personnel: All relevant personnel, including nursing staff, respiratory therapists, and maintenance staff, will undergo training on the safe handling, storage, and operation of medical gas systems. Training will include: o Proper storage requirements for cylinders. o Correct usage procedures for medical gases. o Emergency procedures for medical gas-related incidents. Timeline: All training will be completed by 5/19/2025. 2. Routine Inspections: The facility will implement a more rigorous inspection schedule to ensure compliance with medical gas storage and maintenance protocols. These inspections will include: o Daily checks on the secure storage of medical gas cylinders. o Monthly audits of medical gas equipment and systems. o Annual external inspections from a licensed contractor. Timeline: Inspections will begin immediately and will be ongoing, with the first audit report due by 5/19/2025. 3. Medical Gas System Maintenance: A qualified technician will perform a full service and calibration of all medical gas systems and pressure gauges. Any faulty equipment will be promptly repaired or replaced. Timeline: Full inspection and maintenance will be completed by 5/19/2025.	

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K 926	Continued From page 21	K 926	4. Update Medical Gas Storage Procedures: The facilitys medical gas storage policies and procedures will be reviewed and updated to ensure that they reflect current safety standards. Which will include: o Proper segregation of medical gases from other flammable materials. o Adequate ventilation in medical gas storage areas. o Compliance with NFPA 99 and OSHA standards. Timeline: The policy update will be completed by 5/19/2025 _____ D. Monitoring and Ongoing Compliance 1. Quarterly Audits: Quarterly audits will be conducted by the Safety Committee to ensure ongoing compliance with the medical gas standards and the facilitys policies. 2. Regular Staff Re-Education: Biannual refresher courses will be implemented for all staff involved in the handling of medical gases to ensure continual adherence to safety protocols. 3. Review and Report: The facilitys Quality Assurance team will monitor the medical gas systems performance through ongoing review of incidents, audits, and inspections. Findings will be reported to the facilitys leadership team for corrective actions as needed. _____ E. Responsible Person(s) " Andrea Holly, Director of Nursing or	

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K 926	Continued From page 22	K 926	Designee, will be responsible for overseeing the training and education of staff. " Jesse Warner, Maintenance Director or Designee, will ensure that inspections, audits, and maintenance schedules are adhered to. " Tresha Melquist, Administrator or Designee, will be responsible for reviewing and updating the facilitys medical gas policies. _____ F. Completion Date The Plan of Correction will be fully implemented by 5/22/2025, and the facility will remain in compliance with K926 Medical Gases moving forward.	