Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 29, 2023

Administrator
Cook Community Hospital
10 Southeast Fifth Street
Cook, MN 55723

RE: CCN: 245392
Cycle Start Date: July 13, 2023

Dear Administrator:

On September 21, 2023, we notified you a remedy was imposed. On September 27, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 1, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 13, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of Sept 21, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 13, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 1, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 29, 2023

Administrator
Cook Community Hospital
10 Southeast Fifth Street
Cook, MN 55723

Re: Reinspection Results
Event ID: WR4M12

Dear Administrator:

On September 27, 2023 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 July 13, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 14, 2023

Administrator
Cook Community Hospital C&NC
10 Southeast Fifth Street
Cook, MN 55723

RE: CCN: 245392
Cycle Start Date: July 13, 2023

Dear Administrator:

On July 13, 2023, 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:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 October 13, 2023 (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 January 13, 2024 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
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
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 14, 2023

Administrator
Cook Community Hospital C&NC
10 Southeast Fifth Street
Cook, MN 55723

Re: State Nursing Home Licensing Orders
Event ID: WR4M11

Dear Administrator:

The above facility was surveyed on July 10, 2023 through July 13, 2023 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:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 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
	245392	A. BUILDING _____ B. WING _____	C 07/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 7/10/23-7/13/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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 7/10/23-7/13/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed The following complaints were reviewed with no deficiency issued. H53923509C (MN94403) H53923508C (MN88677) H53923510C (MN85186) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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.	F 000		

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

Electronically Signed | 08/17/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure self-administration of medications was assessed for safety and care planned accordingly to reduce the risk of an adverse event for 1 of 5 residents (R20) observed during medication administration. Findings include: R20's annual Minimum Data Set (MDS) assessment dated 6/23/23, indicated R20 had diagnoses of diabetes, depression, pancreatic cancer with surgically removed pancreas, breast cancer, and hyperthyroidism. In addition, R20's MDS indicated R20 was cognitively intact and received insulin, antidepressant, and diuretic medications on 7 of 7 days during the assessment period. R20's current physician order report dated 7/12/23, indicated R20 received the following medications: acetaminophen 1000 milligrams (mg) three times	F 554	1) R20's artificial tears were immediately removed from bedside on 7/13/23. 2) 7/13/23- DON re-educated all licensed nursing staff that no medication (prescription or over the counter) can be left at bedside or set up by the licensed nurse for the resident to take independently without being witnessed by the nurse without an order and Self Administration of Medication Assessment completed with the resident found competent to do so. 3) 7/29/23- RN Nurse Manager performed a Self Administration of Medications assessment with R20. R20 did not feel comfortable self administering any medications except her Creon which she was competent to perform. R20 knew all side effects, dosage, identification, purpose of medication. The licensed nurse will store this medication on the medication cart, set up the medication as per medication protocol and will leave the Creon for resident to take at the	9/1/23

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F 554	Continued From page 2 daily polyethylene glycol 17 grams (gm) daily as needed mirtazapine 7.5 mg at bedtime insulin glargine 10 units at bedtime insulin ASPART 9 units daily and sliding scale artificial tears one drop each eye three times daily spironolactone 25 milligrams (mg) daily docusate 200 mg every two days aspirin 81 mg daily paroxetine 40 mg daily acetaminophen 1000 mg twice daily magnesium chloride twice daily Creon two capsules four times daily During an observation on 7/12/23 at 7:59 a.m., licensed practical nurse (LPN)-A entered R20's room administered R20's insulin, and instilled artificial tears which were kept at R20's bedside. LPN-A then left R20's medication cup with her pills on her bedside tray, stating she typically leaves the medication for R20 to take and then she checks to see if they were all taken when she would return to pick up the meal tray. Medications in the cup were as follows: spironolactone (treats high blood pressure and fluid retention) 25 mg daily aspirin (can reduce the risk of heart attack) 81 mg daily paroxetine (treats depression) 40 mg daily acetaminophen (can treat minor aches and pains) 500 mg two tablets three times a day magnesium chloride (heart dietary supplement) twice a day Creon (used to aid food digestion for people without a pancreas) two capsules four times a day	F 554	scheduled times with meals and snacks. The licensed nurse does return to R20's room to ensure she has taken the medication as scheduled. R20 is competent to perform and will be monitored with the Self Administration of MEds Assessment performed quarterly at Care Conferences and with any changes in condition/order. A physician order was obtained for R20 to Self Administer the Creon and R20's care plan was updated to reflect the Self Administration, plan and goals. 4) 7/12/23- DON went into all residents rooms in the Care Center to ensure there were no other medications stored at bedside with no others found. 5) 7/13/23- DON verified with licensed nursing that no other medications are left at bedside after set up, for the resident to administer themselves. With no other residents self administering without an assessment and order. 6) 8/15/23- DON created a QAPI to ensure compliance with the medication administration, storage, and self administration of medication policies. On 7/17/23 DON began performing room audits and audits of medication administration to ensure medications are not left with residents to administer after licensed nursing set up or stored in the residents room without the proper self administration of medications assessments and orders from the physician. This has been done weekly x 4 weeks, then monthly x 12 months. 7) 8/16/23- All licensed Nursing staff were re-educated and competency tested	

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F 554	Continued From page 3 During an interview on 7/13/23 at 9:47 a.m. the director of nursing stated staff can not leave medications in a resident's room unless they had an order for self-administration of medications (SAM) and had been assessed to be safe to self-administer their medications. During an interview on 7/13/23 at 9:54 a.m. the administrator verified nursing staff needed to stay with the resident until they took their medications or do an assessment for self-administration and obtain a physicians order for SAM. During an interview on 7/13/23 at 12:04 p.m., the pharmacist (P)-A stated a resident would need an order for SAM and an assessment for ensure they are safe to self-administer medications. PA-A stated nursing would need to stay and physically ensure the resident took all of their medications. The policy Self-Administration of Medication dated 4/13/17, indicated staff and the practitioner would ask residents if they wanted to self-administer their medications. The policy indicated the SAM wood be conducted initially and then periodically for example at quarterly care conferences. In addition, the policy directed "Staff shall identify and give to the Charge Nurse any medications found at the bedside that are not authorized for bedside storage, for return to the family or responsible party.	F 554	on Self Administration of Medications, Storage of medications, physician orders regarding Self Administration of Meds. All new employees have and will continue to receive education and competency testing upon hire for Self Administration of Medications, storage of medications and physician order requirements.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		10/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK COMMUNITY HOSPITAL C&NC	10 SOUTHEAST FIFTH STREET COOK, MN 55723

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F 677	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with grooming for 1 of 2 residents (R25) reviewed for activities of daily living (ADL)'s. Findings include: R25's quarterly Minimum Data Set (MDS) assessment dated 6/22/23, indicated R25 had diagnoses of malignant neoplasm of prostate (cancer of prostate), spinal stenosis lumbar region (a narrowing of the spinal canal, compressing the nerves traveling through the lower back into the legs that may cause pain or numbness in legs), weakness, and dementia. In addition, R25's MDS indicated he required supervision with activities of daily living (personal hygiene/grooming, bathing, toilet use). R25's MDS indicated he was occasionally incontinent of bladder. R25's care plan initiated on 3/29/23, indicated R25 had a self-care deficit with a goal to maintain optimal bathing/hygiene ability. The care plan indicated R25 required an assist of one with cares. During an interview on 7/11/23 at 9:37 a.m., R25's family member (FM)-A stated R25 would like to be shaved daily and needed help with this. During an observation on 7/11/23 at 11:47 a.m., R25 was seated in the common area at the counter he was dressed in clean clothes and wearing shoes and socks. R25 was noted to have beard growth (white stubble) on his face (chin and cheeks).	F 677	1). On 7/12/23 R25 was assisted via one staff to shave his facial hair. 2) On 7/12/23 R25's Care plan was reviewed and found to include staff to supervise or assist of one with hygiene/grooming. 8/16/23 DON determined resident to require assist of one for hygiene/shaving his facial hair. R25's care plan was updated to include daily assistance of one staff to shave his facial hair as R25 allows. 3) On 7/18/23 DON and MDS/RN Educator re-educated all staff to provide timely assistance when opportunities arise to provide shaving assistance to all residents, regardless of their level of assistance care planned. Nursing is to report any needed changes in level of assistance for the residents to the MDS/RN Educator, Nurse Manager or DON immediately. 4) 8/16/23- MDS/RN Educator provided formalized re-education to all nursing staff with competencies regarding ADL Assistance, Care Plan vs. potential resident need/desire and providing assistance. 5) New employee orientation has and continues to include education and competency testing for assistance to residents based on desire not need, care plan and communicating any changes or needs to the MDS Coordinator/DON to assess and implement any necessary changes to level of assistance for ADL's. 6) On 8/15/23- DON created a QAPI to be performed by Nurse Manager and will	

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F 677	Continued From page 5 During on observation on 7/11/23 at 3:03 p.m., R25 walked out to the common area and asked a nursing assistant (NA)-A about where his razor was. NA-A told R25 she didn't think it was lost but did not go to his room to help him find it. During an observation on 7/11/23 at 3:09 p.m., R25 was in his room, activities aid (AA)-A was heard to say she would ask staff to look for his razor. R25 came out of his room and said, "I sure wonder what happened to my razor." AA-B asked R25 if she could go into his room and look for his razor, he gave her permission. AA-B came out of R25's room and said she found his razor and told him she had placed it on the counter in the bathroom. During an observation on 7/12/23 at 1:38 p.m., R25 was in his room on his bed. His beard was about 1/4 inch in length. When he was asked if he was growing a beard, he said he couldn't shave because he couldn't find his razor. During an interview on 7/12/23 at 1:43 p.m., NA-A stated it could sometimes be hard to get R25 to complete cares. NA-A stated they needed to do cares when he was ready. NA-A verified R25 was looking for his razor to shave the day before and no one helped him get set up to shave on his own. NA-A verified it was a missed opportunity to help him with cares. During an interview on 7/12/23 at 2:01 p.m., licensed practical nurse (LPN)-A verified staff should have helped R25 with shaving when he was asking about his razor the day before. During an interview on 7/13/23 at 10:25 a.m., the	F 677	include audits 2x/week x 4 weeks, then 1x/week x 8 weeks and based on results will determine future needs for frequency. The QAPI will consist of audits on all residents, including R25 to observe for any facial hair removal not completed or assisted with, opportunities to provide assistance to residents with facial hair and completion of desired hygiene.	

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	245392	A. BUILDING _____ B. WING _____	C 07/13/2023

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

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F 677	Continued From page 6 director of nursing (DON) stated she would expect staff to help a resident with shaving especially if they were talking about/looking for their razor. The facility policy on activities of daily living was requested but not provided.	F 677		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		8/16/23

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F 755	Continued From page 7 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure controlled medications were monitored and reconciled to prevent diversion of controlled medications. Findings include: During a review of the south medication cart on 7/13/23 at 10:59 a.m., it was noted there were approximately six narcotic cards (cards with narcotic medications in the cards) in the locked medication drawer of the medication cart. The bound narcotic book had medications signed onto pages in the one hundreds, with many pages with a line draw across the page. The director of nursing (DON) who was present for review of the cart stated they did not use the index page to sign the narcotics into the book. The DON stated when a narcotic was no longer in use and not in the narcotic drawer they would draw a line through the page which would indicate the narcotic was no longer in the drawer. Several cards were compared to the page number on the card and both matched. When the DON was asked how they would know if a card was missing she stated she was not sure. During an interview on 7/13/23 at 11:13 a.m., the director of nursing (DON) stated she was not sure why the facility was not using the index page to sign in narcotics. The DON stated the change of shift count was done with two staff. One staff would take out a card call out the page number the second staff would find the page number and	F 755	1)- 7/13/23- DON immediately implemented and filled out the index within the bound Narcotic book to ensure use of. 2) 7/13/23- All Licensed nursing staff were educated 1:1 by the DON on the new required procedure for counting, receiving, discontinuing and signing off on narcotics. DON provided through the education a copy of the updated policy for Controlled Substance Medication. 3) The new procedure for Narcotics received is - the pharmacy delivers the narcotic to the Nurse, the nurse enters the narcotic into the narcotic bound book index page after counting it with the pharmacy. The pharmacy personnel enters the narcotic on the coordinating page of the bound narcotic book. 4) The narcotic is signed off by the nurse administering the medication on the corresponding record page of the narcotic bound book. 5) The shift to shift narcotic count is completed with the two nursing personnel utilizing the index in the front of the narcotic bound book, with verification against the record page in the narcotic bound book and the narcotic medication card itself. 6) 7/27/23- DON initiated audit on proper use of the index page of the narcotic record book to prevent potential drug diversion. Audits are completed weekly x4	

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F 755	Continued From page 8 they would verify the numbers matched (card to the book). The DON verified this system would not detect a missing card. During an interview on 7/13/23 at 11:41 a.m., the administrator verified the facility did not sign narcotics into the bound narcotic book using the index page. The administrator stated one staff would take out a card call out the page number the second staff would find the page number and they would verify the numbers matched. The administrator verified a missing card would possibly not be noticed during the count but would eventually be found when the resident asked for the medication. The administrator verified this process had the potential for diversion. During an interview on 7/13/23 at 12:08 p.m., the pharmacist (P)-A stated the procedure for signing narcotics into the locked medication drawer in the medication cart was to place a sticker on the first blank page of the bound narcotic book, write the number of the page on the card and place the card into the locked narcotic drawer. A nursing staff and a staff member from pharmacy would do this together. P-A stated staff should be using the index page to sign narcotic medications into the bound book. P-A stated if the index page was not being used staff would need to look at each page in the book to ensure there were no cards missing during the shift to shift counts. The facility policy Controlled Substance Medication dated 10/2022, directed staff to do the following: "b) Controlled medications for residents will be received and documented into a bound inventory	F 755	weeks, then monthly x 6 months. Audits will be completed by the DON. 8/16/23 DON created a QAPI to include these audits as written and will continue with this plan for monitoring compliance. 7) Pharmacist updated the Controlled Substance Medication policy on 7/18/23 to reflect the new procedure listed above.	

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F 755	Continued From page 9 book with both pharmacy staff and nursing staff documenting receipt. d) A running inventory will be maintained in the bound inventory book."	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were labeled appropriately with open dates. In	F 761	1) On 7/13/23 R9, R12, R15, and house undated and expired medications were disposed of by DON	9/1/23

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F 761	Continued From page 10 addition, the facility failed to remove expired medications for 3 of 14 residents (R9, R12, R15) whose medications were observed during medication storage. Findings include: During the medication storage tour on 7/13/23 at 10:59 a.m., with the director of nursing there were medications with open and expiration dates lacking and/or items past the expiration date. In addition, there were several expired stored medications observed: R9's Latanoprost eye drops (used to treat certain kinds of glaucoma) had a yellow sticker with an open date filled in for 6/18/23 and an expiration date (discard date) of 7/7/23. R9's lubricant eye drops had a yellow sticker with no open date and no expiration date. R9's Symbicort inhaler (used to treat COPD) had an open date of 4/6/23, and an expiration date of 7/6/23. R12's milk of magnesia had a manufacturer's expiration date of 5/2023. R15's M-PAP liquid (a generic form of acetaminophen) had a manufacturer's expiration date of 5/2023. House use nystatin powder (used to treat fungal or yeast infections of the skin) had a manufacturer's expiration date of 4/2023. During an interview on 7/13/23 at 11:13 a.m., the director of nursing (DON) stated staff should be	F 761	R9's- Latanoprost eye drops, Symbicort inhaler R12's Milk of Magnesia R15's M-PAP House- Nystatin powder 2) 7/13/23 DON further assessed both the south and north medication carts for any further expired medications or unlabeled open dates/expired. No further medications/tx's were found to be expired or not labeled. 3) 7/13/23- DON immediately re-educated all licensed nursing staff in regards to properly labeling of medications when medication requires labeling with the open/expired date. Additionally, education was provided on requirement to use the 6 rights and 3 checks upon administering each medication. Expiration date is to be checked by the nurse prior to administration of medications of any medication or tx. 4) 7/17/23- Nurse Manager began audits of the medication carts and medication room to identify if were / are any expired or unlabeled medications. Audits will continue at 1 x per week x 4 weeks, then monthly x 12 months. 8/16/23- DON created a QAPI to ensure compliance with medication labeling, storage and handling of medications/supplies. QAPI will be ongoing. 5) 8/16/23- MDS/RN Educator provided a re-education and competency testing to all licensed nursing staff in regards to expiration, labeling, storage and handling of medications/tx's. 6) New RN/LPN staff will continue to receive via the RN Educator education	

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F 761	Continued From page 11 filling in the open and expiration dates upon opening new medications and night staff should be checking for expired medications. The DON stated there should not be expired medications in the medication cart. During an interview on 7/13/23 at 12:06 p.m., the pharmacist (P)-A stated he would expect the nursing staff to be checking for expired medications on a scheduled basis. P-A stated the yellow stickers with the open and expiration date should be filled out when the medication is first opened. PA-A stated some medications lose there effectiveness after a specific number of days and there is also the possibility of contamination for some medications and that is why they are discarded after a specific number of days. The policy Administration of Medications in Long Term Care dated 4/11/22, directed staff to do the following: "18. Date opened stickers will be attached to all insulin vials and eye drops. Expiration date will be determined based on date opened: a. Insulin: 28 days from date opened b. eye drops: 45 days from date opened"	F 761	and competencies on labeling/storage and handling of medications.	

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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 7/10/23-7/13/23, a licensing 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 correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 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 surveyors 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 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. 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	2 000		

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. In addition, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed during the survey. H53923509C (MN94403) H53923508C (MN88677) H53923510C (MN85186) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 850	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 850	CORRECTED	9/1/23

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2 850	Continued From page 3 review, the facility failed to provide assistance with grooming for 1 of 2 residents (R25) reviewed for activities of daily living (ADL)'s. Findings include: R25's quarterly Minimum Data Set (MDS) assessment dated 6/22/23, indicated R25 had diagnoses of malignant neoplasm of prostate (cancer of prostate), spinal stenosis lumbar region (a narrowing of the spinal canal, compressing the nerves traveling through the lower back into the legs that may cause pain or numbness in legs), weakness, and dementia. In addition, R25's MDS indicated he required supervision with activities of daily living (personal hygiene/grooming, bathing, toilet use). R25's MDS indicated he was occasionally incontinent of bladder. R25's care plan initiated on 3/29/23, indicated R25 had a self-care deficit with a goal to maintain optimal bathing/hygiene ability. The care plan indicated R25 required an assist of one with cares. During an interview on 7/11/23 at 9:37 a.m., R25's family member (FM)-A stated R25 would like to be shaved daily and needed help with this. During an observation on 7/11/23 at 11:47 a.m., R25 was seated in the common area at the counter he was dressed in clean clothes and wearing shoes and socks. R25 was noted to have beard growth (white stubble) on his face (chin and cheeks). During on observation on 7/11/23 at 3:03 p.m., R25 walked out to the common area and asked a nursing assistant (NA)-A about where his razor	2 850		

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2 850	Continued From page 4 was. NA-A told R25 she didn't think it was lost but did not go to his room to help him find it. During an observation on 7/11/23 at 3:09 p.m., R25 was in his room, activities aid (AA)-A was heard to say she would ask staff to look for his razor. R25 came out of his room and said, "I sure wonder what happened to my razor." AA-B asked R25 if she could go into his room and look for his razor, he gave her permission. AA-B came out of R25's room and said she found his razor and told him she had placed it on the counter in the bathroom. During an observation on 7/12/23 at 1:38 p.m., R25 was in his room on his bed. His beard was about 1/4 inch in length. When he was asked if he was growing a beard, he said he couldn't shave because he couldn't find his razor. During an interview on 7/12/23 at 1:43 p.m., NA-A stated it could sometimes be hard to get R25 to complete cares. NA-A stated they needed to do cares when he was ready. NA-A verified R25 was looking for his razor to shave the day before and no one helped him get set up to shave on his own. NA-A verified it was a missed opportunity to help him with cares. During an interview on 7/12/23 at 2:01 p.m., licensed practical nurse (LPN)-A verified staff should have helped R25 with shaving when he was asking about his razor the day before. During an interview on 7/13/23 at 10:25 a.m., the director of nursing (DON) stated she would expect staff to help a resident with shaving especially if they were talking about/looking for their razor.	2 850		

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2 850	Continued From page 5 The facility policy on activities of daily living was requested but not provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents who need assistance with personal cares are assisted with cares. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 850		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure self-administration of medications was assessed for safety and care planned accordingly to reduce the risk of an adverse event for 1 of 5 residents (R20) observed during medication administration. Findings include:	21565	CORRECTED	9/1/23

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	00586	A. BUILDING: _____ B. WING _____	C 07/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21565	Continued From page 6 R20's annual Minimum Data Set (MDS) assessment dated 6/23/23, indicated R20 had diagnoses of diabetes, depression, pancreatic cancer with surgically removed pancreas, breast cancer, and hyperthyroidism. In addition, R20's MDS indicated R20 was cognitively intact and received insulin, antidepressant, and diuretic medications on 7 of 7 days during the assessment period. R20's current physician order report dated 7/12/23, indicated R20 received the following medications: acetaminophen 1000 milligrams (mg) three times daily polyethylene glycol 17 grams (gm) daily as needed mirtazapine 7.5 mg at bedtime insulin glargine 10 units at bedtime insulin ASPART 9 units daily and sliding scale artificial tears one drop each eye three times daily spironolactone 25 milligrams (mg) daily docusate 200 mg every two days aspirin 81 mg daily paroxetine 40 mg daily acetaminophen 1000 mg twice daily magnesium chloride twice daily Creon two capsules four times daily During an observation on 7/12/23 at 7:59 a.m., licensed practical nurse (LPN)-A entered R20's room administered R20's insulin, and instilled artificial tears which were kept at R20's bedside. LPN-A then left R20's medication cup with her pills on her bedside tray, stating she typically leaves the medication for R20 to take and then she checks to see if they were all taken when she would return to pick up the meal tray. Medications	21565		

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21565	Continued From page 7 in the cup were as follows: spironolactone (treats high blood pressure and fluid retention) 25 mg daily aspirin (can reduce the risk of heart attack) 81 mg daily paroxetine (treats depression) 40 mg daily acetaminophen (can treat minor aches and pains) 500 mg two tablets three times a day magnesium chloride (heart dietary supplement) twice a day Creon (used to aid food digestion for people without a pancreas) two capsules four times a day During an interview on 7/13/23 at 9:47 a.m. the director of nursing stated staff can not leave medications in a resident's room unless they had an order for self-administration of medications (SAM) and had been assessed to be safe to self-administer their medications. During an interview on 7/13/23 at 9:54 a.m. the administrator verified nursing staff needed to stay with the resident until they took their medications or do an assessment for self-administration and obtain a physicians order for SAM. During an interview on 7/13/23 at 12:04 p.m., the pharmacist (P)-A stated a resident would need an order for SAM and an assessment for ensure they are safe to self-administer medications. PA-A stated nursing would need to stay and physically ensure the resident took all of their medications. The policy Self-Administration of Medication dated 4/13/17, indicated staff and the practitioner would ask residents if they wanted to self-administer their medications. The policy indicated the SAM wood be conducted initially	21565		

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21565	Continued From page 8 and then periodically for example at quarterly care conferences. In addition, the policy directed "Staff shall identify and give to the Charge Nurse any medications found at the bedside that are not authorized for bedside storage, for return to the family or responsible party. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident's who self-administer medications have been assessed to ensure they are able to do this safely. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21615	MN Rule 4658.1340 Subp. 2 MedicineCabinet & Preparation Area;ScheduleII Subp. 2. Storage of Schedule II drugs. A nursing home must provide separately locked compartments, permanently affixed to the physical plant or medication cart for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure controlled medications were monitored and reconciled to	21615	CORRECTED	9/1/23

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21615	Continued From page 9 prevent diversion of controlled medications. Findings include: During a review of the south medication cart on 7/13/23 at 10:59 a.m., it was noted there were approximately six narcotic cards (cards with narcotic medications in the cards) in the locked medication drawer of the medication cart. The bound narcotic book had medications signed onto pages in the one hundreds, with many pages with a line draw across the page. The director of nursing (DON) who was present for review of the cart stated they did not use the index page to sign the narcotics into the book. The DON stated when a narcotic was no longer in use and not in the narcotic drawer they would draw a line through the page which would indicate the narcotic was no longer in the drawer. Several cards were compared to the page number on the card and both matched. When the DON was asked how they would know if a card was missing she stated she was not sure. During an interview on 7/13/23 at 11:13 a.m., the director of nursing (DON) stated she was not sure why the facility was not using the index page to sign in narcotics. The DON stated the change of shift count was done with two staff. One staff would take out a card call out the page number the second staff would find the page number and they would verify the numbers matched (card to the book). The DON verified this system would not detect a missing card. During an interview on 7/13/23 at 11:41 a.m., the administrator verified the facility did not sign narcotics into the bound narcotic book using the index page. The administrator stated one staff would take out a card call out the page number	21615		

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21615	Continued From page 10 the second staff would find the page number and they would verify the numbers matched. The administrator verified a missing card would possibly not be noticed during the count but would eventually be found when the resident asked for the medication. The administrator verified this process had the potential for diversion. During an interview on 7/13/23 at 12:08 p.m., the pharmacist (P)-A stated the procedure for signing narcotics into the locked medication drawer in the medication cart was to place a sticker on the first blank page of the bound narcotic book, write the number of the page on the card and place the card into the locked narcotic drawer. A nursing staff and a staff member from pharmacy would do this together. P-A stated staff should be using the index page to sign narcotic medications into the bound book. P-A stated if the index page was not being used staff would need to look at each page in the book to ensure there were no cards missing during the shift to shift counts. The facility policy Controlled Substance Medication dated 10/2022, directed staff to do the following: "b) Controlled medications for residents will be received and documented into a bound inventory book with both pharmacy staff and nursing staff documenting receipt. d) A running inventory will be maintained in the bound inventory book." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure narcotic medications were	21615		

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21615	Continued From page 11 signed into the bound narcotic book using the index page to minimize the potential for diversion. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21615		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were labeled appropriately with open dates. In addition, the facility failed to remove expired medications for 3 of 14 residents (R9, R12, R15) whose medications were observed during medication storage. Findings include: During the medication storage tour on 7/13/23 at 10:59 a.m., with the director of nursing there were medications with open and expiration dates lacking and/or items past the expiration date. In addition, there were several expired stored medications observed: R9's Latanoprost eye drops (used to treat certain kinds of glaucoma) had a yellow sticker with an	21620	CORRECTED	9/1/23

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21620	Continued From page 12 open date filled in for 6/18/23 and an expiration date (discard date) of 7/7/23. R9's lubricant eye drops had a yellow sticker with no open date and no expiration date. R9's Symbicort inhaler (used to treat COPD) had an open date of 4/6/23, and an expiration date of 7/6/23. R12's milk of magnesia had a manufacturer's expiration date of 5/2023. R15's M-PAP liquid (a generic form of acetaminophen) had a manufacturer's expiration date of 5/2023. House use nystatin powder (used to treat fungal or yeast infections of the skin) had a manufacturer's expiration date of 4/2023. During an interview on 7/13/23 at 11:13 a.m., the director of nursing (DON) stated staff should be filling in the open and expiration dates upon opening new medications and night staff should be checking for expired medications. The DON stated there should not be expired medications in the medication cart. During an interview on 7/13/23 at 12:06 p.m., the pharmacist (P)-A stated he would expect the nursing staff to be checking for expired medications on a scheduled basis. P-A stated the yellow stickers with the open and expiration date should be filled out when the medication is first opened. PA-A stated some medications lose there effectiveness after a specific number of days and there is also the possibility of contamination for some medications and that is why they are discarded after a specific number of	21620		

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21620	Continued From page 13 days. The policy Administration of Medications in Long Term Care dated 4/11/22, directed staff to do the following: "18. Date opened stickers will be attached to all insulin vials and eye drops. Expiration date will be determined based on date opened: a. Insulin: 28 days from date opened b. eye drops: 45 days from date opened" SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure medications are labeled appropriately for expiration and ensure the medication carts are monitored for expired medications. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21620		

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	245392	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/11/2023**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/11/2023. At the time of this survey, Cook Community Hospital C & NC 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/18/2023

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 Healthcare Fire Inspections State Fire Marshal Division 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. Cook Hospital C & NC is a 1-story building with a partial basement. The original building was constructed in 1960 with additions in 1966, 2000, 2005, and 2017. The original 1960 building and the 1966, 2000, and 2005 additions are all Type II (111) construction. The 2017 addition was determined to be of Type II(000) construction. The original building and all of the additions including the 2017 which had plans approved prior to July 5, 2016 were considered existing building for inspection purposes and the facility	K 000		

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K 000	Continued From page 2 was inspected as 1 building. The facility has 2 smoke compartments and is separated from the hospital by a 2 hour fire rated wall. The building is fully fire sprinkler protected.. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 28 beds and had a census of 25 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.	K 351		8/29/23

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K 351	Continued From page 3 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 07/11/2023, between 10:00am and 1:00pm, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in IT Storage/Air Handler Room. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 351	1) 8/17/23- Maintenance removed all storage materials placed on a storage rack to ensure that the clearance is 18" as per the requirement. 2) Department Managers were re-educated as to the requirement with storage areas and to maintain the 18" at all times from the sprinkler head. 3) The storage cabinet will be removed from the basement storage area, and a shorter rack will be installed to ensure items are stored at the proper height. This will be completed by 8/29/23. 4) All storage areas, including the basement storage areas are included in our Safety Audits and are assigned through our Safety Officer every 6 months. To ensure compliance with this storage area, maintenance will audit monthly x 6 months.	
K 353 SS=F	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 Protection Systems. Records of system design,	K 353		8/17/23

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K 353	Continued From page 4 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 maintain the sprinkler system in accordance with the 2012 edition of the Life Safety Code (NFPA 101), section 9.7.5, and NFPA 25 2011 edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.2.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 07/11/2023, between 10:00am and 1:00pm, it was revealed that data cables and low voltage wires were attached to sprinkler pipes in the basement corridor outside of laundry room. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 353	7/26/23- Maintenance removed all low voltage wires and data cables that were attached to sprinkler pipes in the basement corridor outside of the laundry room. 7/26/23- Maintenance inspected all other sprinkler pipes to ensure that other areas did not have any low voltage wires and data cables on the sprinkler pipes. 7/14/23- IT Director was re-educated by the Maintenance Director regarding Life Safety Code including that data cables and low voltage wires cannot be affixed in any way to Sprinkler pipes. IT Director will educate all incoming contractors that are working with the low voltage wires and data cables of the requirement and will ensure no further projects have cables/wires attached to the sprinkler pipes. 7/14/23- Audits will be completed by maintenance on all projects involving low voltage wires/data cables going forward throughout 2023 to ensure compliance.	

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	245392	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/11/2023**

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K 353	Continued From page 5	K 353	Maintenance Director started a QAPI to document ongoing plan and audits completed after contractors and/or IT director begin projects.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain access to portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/11/2023, between 10:00am and 1:00pm, it was revealed by documentation review that the fire extinguishers annual inspection documentation could not be provided. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 355	1)- 8/17/23- Documentation was located in the Life Safety Code binder under the tab of Fire Extinguisher inspections and is dated 6/30/2022. The documentation includes each fire extinguisher, and initials of who inspected it and the date. 2) On 6/30/22 the Annual Fire Extinguisher inspection was completed by Nordini Fire and maintenance staff assisting with the walk through.	8/17/23
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier	K 372		7/25/23

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K 372	Continued From page 6 Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 07/11/2023, between 10:00am and 1:00pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above South Care Center Entry doors. 2) On 07/11/2023, between 10:00am and 1:00pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above North Care Center Entry doors. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 372	1) 7/25/23- Maintenance staff completed the smoke compartment penetration repairs above the north and south entry way doors with an approved smoke barrier and fire wall repair caulking. 2) Prevent further breaches to fire compartments by: Maintenance will monitor contractors work within areas that may have fire barrier modifications due to electrical or plumbing repairs to ensure the fire barrier remains intact.	

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K 541 SS=D	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure the laundry chute door per NFPA 101 (2012 edition), Life Safety Code section 19.5.4.1. These deficient findings could have an isolated impact on the residents within the facility. On 07/11/2023, between 10:00am and 1:00pm, it was revealed by observation that the laundry chute door located on the first floor main corridor did not latch.	K 541	8/2/23- Laundry chute door was replaced on the day that it arrived from the manufacturer by maintenance. The latch is intact and in working order. 8/2/23- Maintenance will monitor the laundry chute door during rounding to ensure it maintains compliance with this requirement.	8/2/23

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K 541	Continued From page 8 An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 541		
K 712 SS=F	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 under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 07/11/2023, between 10:00am and 1:00pm, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: 1) First Shift - fourth quarter 10/06/22 09:33am, first quarter 01/12/23 0920am, second quarter	K 712	7/14/23- Maintenance Director will utilize a scheduling system with his outlook calendar and will schedule maintenance staff on varying shifts to perform the required fire drills are completed on each shift, under varying conditions at least quarterly. Where drills are conducted between 9:00 pm and 6:00 am, a coded announcement will be used vs. audible alarms. 7/14/23- Maintenance will document all fire drills performed on each shift on the Fire Drill log sheet, and will maintain proper documentation of participant records. 8/17/23- Maintenance Director created a QAPI to improve overall compliance with	8/17/23

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K 712	Continued From page 9 04/25/23 1:06pm and third quarter 07/19/22 1:30pm 2) Second Shift fourth quarter 11/15/22 4:17am, first quarter 02/23/23 4:01, second quarter 05/18/23 6:28pm and third quarter 08/31/22 6:12pm 3) fourth quarter 12/27/22 05:15am, second quarter 06/30/23 05:00am and third quarter 09/24/22 05:00am An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 712	this process, ensure fire drills are done as per regulation and will document the fire drills within the QAPI as well. The QAPI will be in place throughout the remainder of 2023.	