

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245392	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/12/2024
NAME OF PROVIDER OR SUPPLIER  Cook Community Hospital C&nc		STREET ADDRESS, CITY, STATE, ZIP CODE  10 Southeast Fifth Street Cook, MN 55723	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47790</b></p> <p>Based on interview and document review, the facility failed to ensure an injury of unknown origin was reported immediately (within two hours) to the State Agency (SA) for 1 of 3 residents (R1) reviewed for injury of unknown origin.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had memory impairment. The MDS indicated R1 required extensive assistance with toilet use, and supervision for bed mobility, transfers, and eating.</p> <p>R1's progress note dated 4/7/24 at 3:01 p.m., indicated at 6:50 a.m. R1 was found in her room in her recliner with a large hematoma (collection of blood outside of a blood vessel) on her right forehead, and a swollen and bruised right eye. R1 was unable to tell staff what happened, and no evidence of a fall was found.</p> <p>R1's Nursing Home Incident Report (NHIR) to the SA dated 4/7/24, indicated the report was submitted on 4/7/24 at 11:25 a.m.</p> <p>On 4/11/24 at 1:05 p.m., licensed practical nurse (LPN)-A stated they were busy that morning, and shorthanded, and she completed the report as soon as she could. LPN-A stated she should have filed the report within two hours.</p> <p>On 4/12/24 at 10:00 a.m., the director of nursing (DON) stated the expectation for an injury of unknown origin would be to report it within two hours.</p> <p>The facility Vulnerable Adult Maltreatment Prevention Plan revised 8/23, directed any mandated reporter who has knowledge of an injury of unknown source/origin shall immediately report but no later than two hours.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47790</b></p> <p>Based on interview and document review, the facility failed to ensure care-planned interventions for safety checks were consistently implemented for 1 of 3 residents (R1) reviewed for injury of unknown origin.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had memory impairment. The MDS outlined R1 required extensive assistance with toilet use and supervision for bed mobility, transfers, and eating.</p> <p>R1's care plan reviewed 3/15/24, identified R1 was to be checked on every hour by staff.</p> <p>On 4/11/24 at 1:05 p.m. licensed practical nurse (LPN)- A stated on 4/7/24, between 6:45 a.m. and 6:50 a.m. she went into R1's room and found R1 in her recliner. R1's right side of her face was bruised, her right eye was swollen shut, and she had a hematoma (collection of blood outside of a blood vessel) on the right side of her forehead. LPN-A stated this was the first time she had seen R1 that day.</p> <p>On 4/11/24 at 3:30 p.m., nursing assistant (NA)-A stated R1 was on hourly safety checks, and the last time she saw R1 was at 4:00 a.m. on 4/7/24. She had not done an hourly safety check on R1 after that time.</p> <p>On 4/12/24 at 9:32 a.m., registered nurse (RN)-A stated the last time she saw R1 on 4/7/24 was around 2:00 a.m. when NA-A was assisting R1 to her bedroom. NA-A was responsible for completing R1's safety checks. For safety checks, the staff were expected to visualize the resident to ensure they were safe.</p> <p>On 4/12/24 at 10:00 a.m., the director of nursing (DON) stated it was expected staff visualize the resident when doing safety checks. If a staff member last checked on a resident who was care planned to have hour checks at 4:00 a.m. and then not again until 6:40 a.m. the care plan was not being followed.</p> <p>The facility policy Falls Program- Care Center revised 4/27/23, directed safety checks are placed for staff to check on the resident, visualize the resident, and ensure that they are in a safe position within the room.</p>