| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245392 | A. Building<br>B. Wing | 04/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Cook Community Hospital C&nc | 10 Southeast Fifth Street<br>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) |
|---|---|
| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842<br><br>Based on interview and document review, the facility failed to develop a baseline care plan to ensure immediate resident needs were identified and addressed for 1 of 5 residents (224) reviewed for comprehensive care planning and new admissions.<br><br>Findings include:<br><br>R224's face sheet indicated an admitted [DATE], with a diagnosis of cerebral vascular accident.<br><br>R224's paper baseline care plan indicated a completion date of 4/7/25.<br><br>During an interview on 4/10/25 at 10:39 a.m., registered nurse (RN)-A stated the initial care plan was filled out in paper form and started at the time of admission. It took about 5 days for the initial care plan to be completed.<br><br>During an interview on 4/10/25 at 11:48 a.m., the director of nursing stated the care plan needed to be done within 24-48hrs after admission.<br><br>Facility policy Charting last reviewed 11/18/24, indicated a baseline care plan would be developed within 24hours of admission addressing pertinent problems/needs of the resident |

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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245392 | A. Building<br>B. Wing | 04/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Cook Community Hospital C&nc | 10 Southeast Fifth Street<br>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) |
|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45842<br><br>Based on interview and document review, the facility failed to comprehensively assess each fall to ensure interventions were followed; and failed to ensure fall interventions were care planned timely and implemented to prevent falls for 1 of 1 resident (R5) reviewed for falls.<br><br>Findings include:<br><br>R5's annual Minimum Data Set (MDS) dated [DATE], identified R5 had moderate cognitive impairment and diagnoses that included dementia, depression, osteoporosis and neurogenic bladder (as medical condition that causes bladder control issues). R5 had a history of fall without injury in the last 90 days. R5 had a bed alarm and chair alarm in place to monitor R5's movement and alerted staff when movement was detected.<br><br>R5's care plan started 9/28/24, identified R5 was at risk for fall as evidenced by a history of falls, wandering, dizziness, impaired balance, impaired cognition and a history of self-transferring. Interventions included a post fall root cause analysis, bed sensor pad, fall risk assessment and vital signs. The care plan lacked any other interventions to attempt to protect the resident from falls.<br><br>R5'S Post Fall Documentation (PFD) form last updated 12/12/24, indicated on 3/29/25 at 10:20 p.m., R5 was found on the floor by the bed after trying to transfer from the wheelchair to the bed. There were no behaviors documented as contributing to the fall other than resident had self-transferred. Nursing assessment indicated no injury occurred. Diagnoses listed as contributing factors included dementia, hypertension, anemia, and neurogenic bladder. The PFD lacked documentation related to last toileted or self-catheterized. Fall precautions in place in place included bed and chair sensors. The form indicated precautions such as floor mats, anti tippers, gripper socks or call signage were in place. The form indicated a post fall root cause analysis was competed, the resident was a high fall risk, and no immediate interventions were implemented. The conclusion indicated current interventions appropriate due to dementia and unable to follow recommendations. The PFD lacked documented information related to if appropriate footwear was on, if the call light was available, and when the resident had last been seen.<br><br>R5's Post Fall & Root Cause Analysis (PFRCA) dated 3/29/25 at 10:32 p.m. indicated the same information as the Post Fall Documentation form. Interventions of frequent checks was also added. The PFRCA lacked any other information related to a comprehensive assessment/investigation into the fall was performed or what was reviewed as part of the PFRCA.<br><br>R5'S Fall Worksheet dated 3/29/25, indicated no new interventions were added to R5's care to attempt to prevent falls.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245392 | A. Building<br>B. Wing | 04/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Cook Community Hospital C&nc | 10 Southeast Fifth Street<br>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) |
|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/8/25 at 9:45 a.m., nurse assistant (NA)-A stated residents would be put on frequent checks after fall for an undisclosed amount of time to keep a close observation of them to prevent further falls. Frequent falls meant they would be observed every 30 minutes and then documented on a paper form where we wrote down when they were checked, who did the check and where they were located at the time of the check. NA-A stated R5 had not been on frequent checks for several months.<br><br>During an interview on 4/8/25 at 10:03 a.m., licensed practical nurse (LPN)-A stated when a resident fell there was a fall assessment that is filled out and then given to the director of nursing (DON). I do not know what happens after that point. LPN-A also stated residents after falls would be placed on frequent checks. Frequent checks could be anywhere from every hour to every fifteen minutes. Documentation of frequent checks were done on a paper form and entered in the computer.<br><br>During an interview on 4/8/25 at 10:39 a.m., registered nurse (RN)-A stated when a fall occurred the fall paperwork was given to the DON and then the DON would give RN-A the paperwork to review. Part of the review process would be to talk with staff about the incident, look at the resident's medical record, and evaluate causes for the fall. A root cause analysis would be performed by myself to decide the cause of the fall and what if any changes need to occur. RN-A reviewed R5's fall paperwork from 12/12/24 and stated a lot of information was missing related to the fall and what occurred at the time of the fall. Interviews with the staff to investigate the fall did not occur so there were unanswered questions related to the fall and why it occurred. RN-A knew R5 and knew she would just keep getting up on her own, so I just copied the information from the nursing documentation onto my review and started frequent checks. RN-A was unable to show the frequent check documentation and stated frequent checks were never started by the staff.<br><br>During an interview on 4/8/25 at 11:10 a.m., the DON stated a complete investigation and root cause analysis should be performed to evaluate why a fall occurred and how to attempt to prevent further falls. Interventions should be care planed and started based on recommendations found through the investigation process.<br><br>The facility policy Falls Program-Care Center last reviewed 4/11/25, indicated the licensed nurse would perform a post fall huddle/root cause analysis to determine any potential contributing factors to a fall. Post fall interventions would be put into place based on the RCA. The nurse manager or DON would then review the fall with reenactment if there were questions or concerns related to the fall. |