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	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cook Community Hospital C&nc	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure care planned fall interventions were implemented for 1 of 4 residents (R29) reviewed for falls. This resulted in actual harm for R29 who fell and sustained a laceration to the forehead, requiring sutures. The facility implemented corrective action prior to the start of survey, and this is issued in past noncompliance. Findings include:R29's admission Minimum Data Set (MDS) dated [DATE], indicated significant cognitive impairment. Diagnosis included dementia with behaviors. Fall history indicated falls 2 to 6 months prior to admission along with a fall with fracture.R29's care plan dated 6/3/25, identified a risk for falls related to a history of falls at home and since admission, impaired balance, impaired mobility, impaired cognition, and psychotropic medication usage. Care planned interventions dated 6/10/25, included not to leave alone in wheelchair in her room. Care planned interventionsˆdated 6/23/25, included bed sensors, Velcro alarmed seat belt, and chair clip alarms on at all times.R29's Care Plan Summary for South Neighborhood dated 8/13/25, indicated R29 needed bed, chair and Velcro belt alarms on always and not to be left alone in her room when in the wheelchair. R29's nurses notes identified the following: - 8/15/25 at 6:30 p.m., R29 was physically aggressive with nurse assistant (NA) this afternoon. R29 was grabbing and pushing NA against wall and scratching NA's arm and chest. R29 received medications for behaviors and became calmer and more cooperative.- 8/16/25 at 10:01 a.m., two family members on the unit requesting information related to R29's fall the night prior.- 8/18/25 at 2:05 p.m., there was a late entry for the date of 8/15/25, that R29 had returned from the emergency room (ER) after receiving 10 stitches to a laceration on the right forehead.The facilities fall investigation and root cause analysis identified the following:R29 had an unwitnessed fall in her bathroom on 8/15/25 at 7:05 p.m., and received a laceration to her forehead, a scratch on the bridge of the nose, and a skin tear to the left wrist.R29's alarms were not sounding at the time of the fall.R29 had behavior problems and had refused to let staff place her seatbelt back on.In conclusion R29 self-transferred from the wheelchair to the bathroom in her room and the alarms were not on at the time of the fall as care planned.Registered nurse (RN)-A interview note dated 8/15/25 indicated R29 was calling out for her husband. R29 was found in her room lying on the floor in her bathroom with a puddle of blood under R29's forehead. The laceration was deep enough to see R29's skull. The note did not state if staff were with R29 in her room prior to the fall. During an interview on 5/27/26 at 2:42 p.m., nurse assistant (NA)-A stated on 8/15/25, evening shift had just started and R29 was having increased behaviors. R29 kept trying to get out of the chair and was setting off the lap belt alarms. She would not let me put the lap belt on her and R29 scratched my arms while I was trying to get the lap belt on her. I was finally able to get the lap belt on her after several minutes but do not remember if the alarm was on when I reattached the alarm.During an interview on 5/27/26 at 2:52 p.m., NA-B stated She was assigned to the south hall, the hall R29 was on. On 8/15/25 at approx. 6:00 p.m., NA-B saw R29 wheel herself into her room. The lap belt was in place but did not know if the alarm was turned on. NA-B stated she attempted to go into R29's room so R29 would not be alone in her room but the registered nurse (RN) stopped her and had NA-B go into another resident room to (continued on next page)

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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F 0689 Level of Harm - Actual harm Residents Affected - Few	assist the RN with cares. No other staff were around to go be with R29 in her room, so R29 was in her room alone in the wheelchair. When they had finished the cares on the other resident the screams from R29's room were heard and staff entered the room and found R29 on the floor in the bathroom with blood on the floor.NA-A stated the staff were aware R29 could not be left alone in her room due to her high risk of falls and self-transfers in the past.On 5/28/26 at 10:44 a.m., RN-A, the PM nurse working on 8/15/25, was called but did not answer and was unable to leave a voicemail due to mailbox being full.On 5/28/26 at 10:54 a.m. RN-B, the AM nurse working on 8/15/25, was called nut did not answer. There was no voicemail to leave a message to call back.During an interview on 5/28/26 at 1:22 p.m., RN-C stated the fall investigation found that the care plan was not followed because the alarms were not turned on while R29 was in the wheelchair and alone in her room.During an interview on 5/29/26 at 9:09 a.m., the director of nursing (DON) stated staff should make sure the care plan is always followed, and alarms were turned on when R29 was out of bed and in the wheelchair.Facility policy Care Plan-Comprehensive Nursing dated 1/15/26, indicated a comprehensive car plan would be developed for each resident that included measurable objectives, and a timetable to meet a resident's medical, nursing, emotional, mental and psychosocial needs. The care plan was kept in the electronic health record and needed to be always followed.The noncompliance that began on 8/15/25 was corrected prior to the start of survey when the facility implemented a corrective action plan on 8/16/25. Actions taken included education related to the importance of following the care plan and education related to the use of lap belt alarms. Shift checks were initiated to verify alarms were on properly along with frequent checks of the residents and alarms. The education and audits were verified through interview and document review. The facility was able to demonstrate monitoring of the corrective action and sustained compliance.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on interview and document review, the facility failed to ensure the nurse staff posting was posted daily and was updated to reflect the current staffing. This had the potential to affect all 24 residents residing in the facility. Findings include:On 5/27/26 at 2:15 p.m., the nurse staff posting was dated 5/26/26.On 5/27/26 at 4:10 p.m., the nurse staff posting was dated 5/26/25.On 5/28/26 at 6:58 a.m., the nurse staff posting was dated 5/26/26.On 5/29/2026 at 8:13 a.m., the nurse staff posting was dated 5/28/26.During an interview on 5/28/26 at 9:08 a.m., nursing assistant (NA)-A verified the nurse staff posting was dated 5/26/26. NA-A stated it was important for families and visitors to see how many staff were working.During an interview on 5/28/26 at 2:24 p.m. staffing coordinator (SC)-B stated she changed the nurse staffing hours on Thursdays for the coming week. SC-B stated she did not update the changes on the posted sheets but would make the changes in the computer after they occurred when she returned on Mondays. A review of the next week's schedules (5/28/26, 5/29/26, 5/30/28, 6/1/26) all had the census as 24. The schedule dated 5/30/26, had zeros for all staff listed and a census of 24.During an interview on 5/29/26 at 8:35 a.m., the director of nursing (DON) verified the nurse staff posting should be posted daily so anyone could see how many residents were in the facility and how many staff were working. The DON stated it was important so families could have confidence there was enough staff to take care of their family members.The Staffing - Care Center policy dated 1/26/26, identified the intent was to ensure sufficient staffing was in place to meet the needs of residents. The policy identified staffing hours would be posted on the bulletin boards in each household and the bulletin board located in the hallway leading to the Care Center from the Business Office. The policy identified the location was for residents, families, visitors, and staff but did not address how frequently the information Daily Staffing would be posted.