STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245392	A. BUILDING _____ B. WING _____	04/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to discontinue communal dining and maintain appropriate social distancing for residents. This had the potential to affect all 28 residents who resided at the facility. In addition, the facility failed to ensure an aerosolized nebulizer treatment was administered in a private room for 1 of 1 residents (R1) reviewed for nebulizer administration. In addition, the facility failed to perform hand hygiene after performing perineal cares to prevent cross contamination for 1 of 1 residents (R2) reviewed for personal cares. Findings include: On 4/2/20, at 9:25 a.m. the north household dining room was observed. Three tables were observed in the dining room. Two square tables measured approximately 4 feet (ft.) x 4 ft., and one rectangular table measured approximately 8 ft. x 4 ft. were located in the commons area. Two place settings at the rectangular table contained dirty dishes, and were observed adjacent to one another. Four place settings, each containing dirty dishes, were observed at each square table. No residents were present in the dining room at this time. On 4/2/20, at 9:33 a.m. the south household commons area was observed. No residents or places settings were observed. On 4/2/20, at 11:34 a.m. three residents were observed at a rectangular table in the south household commons area. One resident was positioned at the end of the table. Two residents were positioned directly across from each other. The residents directly across from each other were approximately 4 ft. apart. On 4/2/20, at 11:36 a.m. two residents were observed positioned adjacent to each other at a square table in the north household commons area. The two residents were approximately 3 ft. from each other. Two other residents were seated at an overhanging countertop which extended from the nursing units kitchenette. These two residents were approximately 2 ft. away from each other. On 4/2/20, at 11:55 a.m. two residents were observed positioned near an overhanging countertop which extended from the south household kitchenette, approximately 3 ft. away from each other. Lunch was being served. Licensed practical nurse (LPN)-A was interviewed and stated the two residents were seated too close together. LPN-A stated residents were supposed to be six feet apart. LPN-A stated she believed the residents seated at the rectangular table were 6 ft. apart. LPN-A stated 14 residents resided on each nursing unit. LPN-A then moved the residents to opposite ends of the overhanging countertop. Seven residents were observed in the dining area during lunch. On 4/2/20, at 11:58 a.m. trained medication assistant (TMA)-A approached the two residents who remained positioned near the overhanging countertop which extended from the north household kitchenette. These residents were approximately 2 ft. away from each other. TMA-A asked one resident if it would be okay to move her because she was too close to the other resident. R6 consented and was moved towards the opposite end of the overhanging countertop. TMA-A placed a chair between the residents. A third resident was observed seated at a square table. All three were within a couple feet of each other. TMA-A stated the three were too close and estimated the residents were 3 ft. apart. TMA-A stated these seating arrangements were typical the past couple of weeks. TMA-A stated the facility had tried different seating arrangements during dining, but was having difficulty keeping residents apart. The three residents were served their meal. A total of ten residents were observed in the north household commons area. On 4/2/20, at 12:51 p.m. dietary aid (DA)-A was interviewed and stated residents were supposed to be spaced 6 ft. apart during meals. On 4/2/20, at 1:07 p.m. nursing assistant (NA)-A stated she tried to keep as much spacing as possible between residents during meals. NA-A stated she tried to keep residents a chair length apart and estimated this was 2 - 3 ft. On 4/2/20, at 1:18 p.m. the director of nursing (DON) was interviewed. The DON confirmed she witnessed residents were too close in the dining room. The DON stated staff had changed resident seating arrangements, within the past day, and had not reported it. The DON confirmed the residents were eating in the dining room. On 4/2/20, at 1:25 p.m. registered nurse (RN)-A stated residents were supposed to be 6 ft. apart during dining. RN-A stated the Minnesota Department of Health (MDH) and Centers for Centers for Disease Control and Prevention (CDC) indicated no communal dining was allowed. RN-A confirmed residents being placed in close proximity of each other was an infection control risk considering COVID-19. A letter addressed to residents and family members dated 3/23/20, indicated As much as possible, residents are kept six feet apart at meals. Due to not enough staff to assist with meals, we are unable to discontinue communal dining at this time for the residents' safety. An email addressed to nursing home staff dated 3/27/20, directed maintain social distraction of at least 6 feet for our residents. R1's [DIAGNOSES REDACTED]. R1's quarterly MDS dated [DATE], indicated R1 had short-term and long-term memory problems. The MDS further indicated R1 required extensive assistance with locomotion. R1's Orders undated, indicated R1 was prescribed an [MEDICATION NAME]/[MEDICATION NAME] ([MEDICATION NAME]) nebulizer four times daily. R1's care plan reviewed 3/4/20, directed Due to coronavirus please do nebulizer treatment in room to minimize the risk of disease spread if she was to have symptomatic illness. R1's Medications report undated, indicated R1 was administered a [MEDICATION NAME] on 4/3/20, at 9:16 a.m. On 4/2/20, at 10:13 a.m. R1 was observed in the north household commons area. R1 was seated in a wheelchair and near a square folding table. R1 was wearing a nebulizer mask. The nebulizer mask was connected to a nebulizer machine. The nebulizer machine was running. At 10:20 a.m. TMA-A approached R1 near the folding table. TMA-A asked R1 if she was finished. TMA-A removed the nebulizer mask from R1's face, and disconnected tubing which was connected to the nebulizer machine. TMA-A held the nebulizer mask in one hand and wheeled R1 towards the activities room. On 4/2/20, at 10:24 a.m. TMA-A returned to the north household commons area. TMA-A rinsed the nebulizer mask and canister with tap water. TMA-A placed the nebulizer mask and canister in a drawer. TMA-A performed hand hygiene with soap and water. TMA-A was interviewed and stated R1 was administered a [MEDICATION NAME] medication within the north household commons area. TMA-A stated R1 preferred to have her nebulizer treatments administered outside of her room. On 4/2/20, at 1:18 p.m. an interview was conducted with the DON. The DON stated a nebulizer treatment was supposed to be administered in a private room. On 4/2/20, at 1:25 p.m. RN-A erroneously stated R1 was care planned to have nebulizer treatments outside of her room. RN-A stated she did not recall seeing R1 have nebulizer treatments near another resident in the north household commons area. R2's [DIAGNOSES REDACTED]. R2's care plan reviewed 2/24/20, indicated R2 had decreased ability to perform self-care related to right-sided [MEDICAL CONDITION]. R2's quarterly MDS dated [DATE], indicated R2 had moderate impaired cognition. The MDS also identified R2 always incontinent of bladder, and frequently incontinent of bowel. R2 required extensive assistance with bed mobility, and was totally dependent upon staff for transfers. On 4/2/20, at 10:38 a.m. NA-B entered R2's room, performed hand hygiene with soap and water, put on gloves, and asked R2 if she wanted to get ready for lunch. NA-B approached R2, who was laying on her back in bed, and lowered the resident's blankets and sweatpants. NA-B observed R2's incontinence product and stated it was wet. NA-B unfastened R2's incontinence product and performed perineal care using wet wipes. The wet wipes and NA-B gloves were disposed of in a garbage can to the immediate left of R2. NA-B then walked to R2's bathroom and opened a cabinet door using a handle. Without performing hand hygiene NA-B donned clean gloves. NA-B returned to R2 and assisted the resident roll to her right side by pushing on the resident's back as R2 pulled on the bed rail. NA-B pulled R2's incontinence product out from underneath her. NA-B rolled the incontinence product and disposed of it in a garbage can. NA-B removed her gloves and performed hand hygiene with soap and water in the bathroom. NA-B put on clean gloves and returned to R2. R2 was asked to roll to her right side and did so without assistance. NA-B tucked a clean incontinence product and lift sheet under R2.

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

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) NA-B then wiped R2's buttocks with wet wipes. NA-B disposed of her gloves and did not perform hand hygiene. NA-B then attempted to assist R2 roll to her left side by pushing on her side, however, the R2 remained partially on her back. NA-B walked to R2's bathroom and opened a cabinet door using a handle. NA-B put on new gloves and did not perform hand hygiene. NA-B returned to R2, and again attempted to roll the resident to her left side. R2 remained partially on her back. NA-B pulled the lift sheet from under R2. NA-B then reached under R2's buttocks and pulled the incontinence product through. NA-B fastened the incontinence product and put new pants on R2. NA-B removed her gloves and performed hand hygiene with soap and water. On 4/2/20, at 11:07 a.m. NA-B confirmed hand hygiene was not performed between glove changes after perineal cares were performed. On 4/2/20, at 1:18 p.m. the DON stated hand hygiene needed to be completed between glove changes. On 4/2/20, at 1:25 p.m. RN-A stated hand hygiene needed to be performed whenever gloves came off an employee. RN-A stated this was an infection control concern. The facility policy Hand Hygiene reviewed 10/19, directed hand hygiene was to be performed before and after touching blood, body fluids, secretions, excretions, or handling any contaminated items such as dressings (even if gloves are used).