COOK HOSPITAL & CARE CENTER
Our Specialty is You

Phone: 218.666.5945
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10 Fifth Street SE
Cook, Minnesota 55723
www.cookhospital.org

1) **The Regular Board Meeting was called to order on Tuesday October 24, 2023, at 5:19 p.m.**

2) **Roll Call**

Board Members Present

Liz Dahl – Linden Grove
Shirley Conaway – Camp 5
Don Potter – Unorganized St. Louis County
Barb Johnson – City of Orr
Theresa Martinson – Angora
Marge Hyppa – Owens
Wendy Long – Leiding
Eric Pederson - City of Cook
Karen Baxter – Unorganized St. Louis County
Mike Enzmann – Field

Board Members Excused

John Stegmeir – Kabetogama
Judy Pearson – Beatty
Denise Parson – Willow Valley
Kathy Weiand - Portage

Board Members Absent

Shirley Sanborn – Crane Lake

Staff Members Present

Teresa Debevec – CEO/Administrator
Stephanie Maki – Human Resources Director
Kaylee Hoard – CFO

3) **Pledge of Allegiance**

4) **Approval of Minutes – 09/25/2023**

- A **motion** was made by Marge Hyppa, seconded by Barb Johnson to approve the September 25, 2023, regular board meeting minutes as presented. All in favor.

  The motion passed unanimously.

5) **Administrators Report - Teresa Debevec**

- **A staffing report was provided:**
  - The Chief Nursing Officer and Assistant Plant Manager have both resigned, we are actively working to recruit those positions.
  - We continue to recruit several positions' facility wide, including:
    - Dietary
    - Nursing Assistants
    - RN/LPN

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- Hospital Biller
- Radiologic Technologist
- Ultrasound Technologist

- On September 1, 2023, the Centers for Medicare & Medicaid Services (CMS) issued the minimum staffing standards for LTC facilities and Medicaid Institutional Payment transparency reporting proposed rules, which seeks to establish comprehensive nurse staffing requirements to hold nursing homes accountable for providing safe and high-quality care for residents. The proposed rule standards include a proposed hardship exemption for select facilities based on location, good faith efforts to hire and retain staff and financial commitment to staffing. We are eligible for this exemption and will be applying through CMS if this proposed rule becomes a regulation.
- A new MD will be starting at Scenic Rivers on October 30th, Dr. Cooley will also be in the call rotation at our hospital.
- Students from Northwoods School will be on-site next week, we will be setting up stations for these students to learn more about healthcare.

6) **Committee Reports**

- **Executive Committee – 10/24/2023 – Liz Dahl**
  - Debevec has renewed her contract with the Hospital.

- **Finance Committee – 10/24/2023 – Kaylee Hoard – Liz Dahl**
  - Financial Report – Kaylee Hoard
    - Hoard provided the September 2023 financial report.
  - Capital – Liz Dahl
    - A recommendation was made by the Finance committee to approve the following capital items:
      - Care Center dishwasher – Not to exceed $9,000.00.
      - Omnicell Server – Not to exceed $32,000.00.

7) **Credentialing Committee – No Meeting**

8) **Safety Meeting – Karen Baxter**

- Karen reported on the safety meeting.

9) **Care Center QAPI – Marge Hyppa**

- Marge reported on the Care Center QAPI meeting, minutes are attached.

10) **New Business & Correspondence**

- Annual Policy Review – Teresa Debevec – Action Needed

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- A recommendation was made by Theresa Martinson, seconded by Marge Hyppa to approve the updates to the following policies:
  - Compliance & Ethics
  - Identity Theft Red Flag – Compliance
  - Vulnerable Adult Plan

TM/MH (MCU)

- **Education – Teresa Debevec**
  - Debevec provided board education on Cook Hospital District and Levy History.

- **Next Board Meeting – 11/28/2023**

- **Questions or comments**

- **Board Meeting Evaluations – Liz Dahl**
  - Provide meeting feedback to Debevec or Dahl

- **Adjourn – Liz Dahl**
  - At 6:05pm., a motion to adjourn the meeting was made by Eric Pederson, seconded by Don Potter.

Minutes respectfully submitted by Stephanie Maki, Human Resources Director – Approved by Teresa Debevec.

QAPI MINUTES

10/19/23 10:00 in LCR

CARE CENTER QAPI's				
Problem/QAPI	**Goal**	Current data	Plan	Assigned to
Incident/Accident Reporting	Decrease number of falls with and without injury **Goal falls with major injury- 6.4% State average**	**July Fall Rate**: 7.9% per 1,000 occupied days **August fall rate**: 3.6 %per 1,000 resident occupied days. **September fall rate: 9** % per 1,000 occupied days July falls; August falls; September falls *****NOTE: No major injuries**	Weekly falls meetings include Nurse Manager, DON, MDS, OT, Restorative. Review RCA, fall interventions, care plan updates, potential contributing factors. **Decreasing Falls is our PIPP choice. New interventions for all of IDT to meet regarding falls M-F, visit the location and provide immediate action plans/interventions and document appropriately. Julie, Brooklyn, and Theresa met in August and reviewed the finalized PIPP, accepted by DHS.	Theresa H., falls team
OHFC/ VA REPORTING	OHFC reporting on time with investigative report completed timely and within regulation.	Third quarter- no reports submitted	Continue to report OHFC /VA reports on time with the investigative report completed on time as well.	Theresa H.

QIIP: Pain **PIPP for 2022**	To reduce resident pain and accuracy of documentation submitted	**Goal is 13.17% (1/1/21 to 12/31/21 QI's MN) **For PIPP full payment.** The current rate is 14.6%, slightly up from the previous report (13.7%) *7/1/22 to 6/30/23. **Adjusted state average is 13.1% Started at 28.6%	*QIIP met our goal and will receive an additional 3.50 per resident/ per day in reimbursement. *Nurse Manager, DON, Continue to Work with MDS to identify pain assessment approaches and findings on each resident. The pain committee meets monthly, seeing improvements in multiple areas. *Monitor s/s of nonverbal pain in cognitively impaired residents Discontinue pain medications that are not necessary or used. Utilize nonpharmacological interventions when applicable. Received portable chair massagers, ordered iPad, ordering virtual reality system, utilizing Aqua K pads, and Activity Director training in Bingocize (per PIPP Grant). Plan to have an educational lunch and learn ongoing regarding Pain. Continue with staff education on pain. Pain PIPP will be addressed at all care conferences with residents and families.	Theresa H.; nursing staff, MDS, Nurse Manager Pain Committee

			Work with physicians to obtain proper and accurate diagnosis. May require referral to urology, imaging, etc. The Medical Director is now attending our Pain/Psychotropic meetings. The pain committee meets monthly. With Pharmacist, DON, Nurse Manager, Medical Director Increase movement- Bingocize. Use of Spa Interactive activities	
PIPP ***NEW AWARDED	Decreasing Falls	*Our PIPP was accepted, and Julie met with Kim Class, DHS 7/29 via TEAMS to review action plan, budget, goals. Julie, Theresa, and Brooklyn met and reviewed new PIPP and requirements	New PIPP in place, see falls, incident rates above.	Julie L.
QIIP: Depression (decrease) For 2023	To decrease reports of depression in residents upon interview	Current rate 3.336%; State adjusted average 3.95 % QI report 7/1/22- 6/30/23 **Just started in July	Team will be formed with Theresa H., Brooklyn, Stephanie Nelson, Amy Rausch	Theresa H; Brooklyn; Stephanie N.
Quality Indicators MN	To improve QI (MN) score ****QI Reporting period last released: 6/22 to 7/23** **Goal: 0.75%**	Improvements needed: - Triggered by the Prevalence of Falls with injury. o Current rate: 1.6. - Prevalence of UTI's- rate: 4.739%; state- 2.9% - Prevalence of moderate to severe pain- 14.60%; state- 13.09%	Continue plan as above, meeting with MDS Coordinator monthly, reviewing each resident flagging for QI, produce an individual plan to improve the measure and reduce flagging. Examine documentation and approaches. QM/QI meetings will be held	Julie L., Theresa H., Brooklyn. Stephanie N, MDS Other team members based on the QI improvement

		- Antipsychotic meds without a dx of psychosis- 10.33%; state- 8.8%	monthly facilitated by Julie L. Work through QAPI projects assigned to staff. QM/QI meetings will be held monthly facilitated by Julie L. and Theresa Explained the difference in the report period with both the QI's and QM's and that although we are meeting regularly and reviewing each individual person that is flagging on the QM's, it will take time to reflect in our numbers as it will have to cover a more recent period.	
Quality Measures	**QM Reporting period **last released:** 01/01/23-06/30/23	QM – Areas of needed improvement: *Falls (68% vs. 50% state average) *Increase in ADL help (15% vs. 14.7% state average) *Antianxiety/Hypnotic- (15% vs. 12.2% state average) *Loss of B/B continence- (60% vs. 51.6% state average)	Continue with same plan as improving QI's, take an individualized look at who is triggering and develop a plan for improvement for those who are flagging. Meet with MDS monthly. Will involve Tony and Dr. Vidor in the decreasing the use of antianxiety/hypnotics	Julie L., Theresa H. Stephanie N.., MDS; Brooklyn
Infection Prevention	UTI Reduction Care Center Goal: one per month	July- 0 August- 1.21 September- 3.87	Michelle has Stephanie on her team with this. Stephanie is providing Day 2 orientation with new staff which	Michelle M

			includes catheter and peri care (video and written competency). This is repeated within 2 months of completion of orientation by an audit and return demonstration.	
MDS/RN Educator	Following toileting plans Goal: 90%	Third quarter: 90% *Trying to determine factors with difference in compliance by staff, as staff members move from side to side.	Monitoring that toileting plans are followed for bowel and bladder and that staff are documenting these appropriately. Education is provided 1:1 to staff that are not documenting correctly. MDS sending out email to all staff on which residents have their ARD to ensure documentation is completed (email is sent the week of their ARD by MDS) Reenforcing previous education to staff that even if a resident refuse, they must chart that they are following the toileting plan, as they are by offering.	Stephanie N., MDS
Infection Prevention	Housekeeping IP	Baseline data: Michelle has obtained baseline data. Third quarter:	Revamped education/training Just began new education with housekeeping.	Michelle M., IP
MDS/RN Educator	Bathing Compliance Goal 100%	North- 90% Compliant South- 60% compliant Total charted	Discussion was held with Julie and Theresa with Stephanie not in attendance at the meeting. Theresa will speak with Stephanie as to what is changing with interventions with the poor overall rates for the third quarter.	Stephanie N.

			Monitoring staff documentation of bathing/showers completed vs. noted on the paper form. Education to staff continually regarding importance of documentation, reapproaching, alternative attempts with other staff members.	
Compliance	Ensuring QAPI projects are up to date. Goal 100%	Work with dept managers that have regs to ensure they are up to date	QAPI projects are up to date and within compliance.	Julie L, DON, Dept managers
CDM- Ensure weights are completed on time	Goal: 100%	Quarter three- July- 96% August- 70% September- 66%	Will continue with new intervention of having the Licensed Nurse document that this is completed on their shift. Per Chris this has shown improvement in October with the new change noted above.	Chris J, / Theresa H./Brooklyn
OT	W/C cleaning Goal: 90%	JULY: North: 13 days were documented with completion of wheelchair washing. 42% South: 15 days were documented with completion of wheelchair washing. 48% AUGUST: North: 6 days initialed. Total 31 days. 19% completion. 4 (33%) residents were not initialed for all of August. South: 11 days initialed. 35%. 2 (25%) residents were not initialed for all of August. SEPTEMBER: North: by 9/18 only 4 dates in Sept were documented with completion of	Educating ADDITIONAL STEPS TAKEN: - Staff concerns: Spoke to staff about their thoughts on wheelchair washing. One person expressed that if evening shift took out the wheelchairs that were to be washed that evening, the night shift would then not know whose wheelchairs they were. The audit was completed to find 100% of wheelchairs in facility had tags of room numbers. - 10/19/23- Per OT, now nursing is physically inspecting w/c's and must document this on a check off sheet on each shift. Sheet is	Amy Kemp, OT

		washing. 22% South: by 9/18 only 2 dates in Sept were documented with completion of washing. 11%	being revised to ensure the documentation is clear.	
Dietary/CDM	Temperature Receiving Logs Goal: 90%	July- 82% August- 87% September- 42% *	Education to staff Monitoring and audits to be completed by CDM. **New action to post signs on walk in cooler and freezer doors as reminders *Per Chris the decrease compliance in September was due to an employee on vacation and he must be the one who normally completes this requirement.	Chris J., CDM
Nursing/Pharmacy	Medication Errors Goal:	10/19/23- Per Theresa, she focused on the state survey medication tags listed below. Audits completed currently in quarter 2, Theresa will report on this in quarter 3 after full implementation of plan of action.	Med errors are currently reviewed by DON. DON then meets with the staff member and determines potential causes contributing. Nursing is re-educated. Med errors are given to the Pharmacist and the Medical Director for review.	Theresa H.; Tony M./Brooklyn
Anti-Anxiety/Hypnotic Use	Goal: State average 12.2%	July-15% August- 16% September- 12%	Meet monthly to review all residents on medication. GDRs are attempted and recommended to physicians by pharmacist as they are scheduled. *Dr. Vidor attends	Theresa H./Tony/Brooklyn/Steph
Antipsychotic Medication use (without dx of psychosis)	Goal: State average 8.8%	July- 11.5% August- 8% September-8%	As above with Anti-anxiety, committee meets monthly to review each resident, diagnosis, need, GDR's	Theresa H./Tony/Brooklyn

Antidepressants	Goal: Is our QIPP also***	July- 38.5% August- 40% September- 40%	Julie discussed the importance of not seeing a rise in the use of other psychotropic medications, when decreasing or removing an anti-psychotic. New regulatory requirements put the emphasis on not seeing a rise in other psychotropics when possible.	Theresa H./ Brooklyn/Tony/Stephanie Amy R.
Activities Sensory Program	Goal: 80%	Just started in September 40%	Using Infants and baby sensory items in program such as lotions, baby dolls, hand massage, flowers, gardening soil, floral scents, etc. Will train the noc shift on utilization of sensory program with residents who get up on the noc shift.	Amy R.
Environmental Services: Fire Damper Inspection Repair project	All dampers to be in operation per LSC. Goal 80%	Fire marshal here 7/23- no concerns noted. New dampers and repairs made per Jamar		Mike T.
Nursing: Bowel Program- accurately recording and utilizing standing orders or PRN orders	Goal: 100	July- 93% August- 86% September- 75%	Theresa will meet with Stephanie to ensure proper documentation is completed and submitted on the MDS. Change interventions when percentage rates for compliance are not improving. Re-educated nursing regarding expectations and bowel program Implemented Licensed nursing to monitor BM's each shift with new form attached to report sheet. Audits completed by Theresa/Stephanie	Theresa H.; Brookly, Stephanie N.
Emergency Preparedness: Ensuring required	Goal: 100%	Active Shooter to be scheduled 4th	10/19- Julie updated the committee on the organization of	Julie L.

drills/tabletops and education are completed		quarter. Requirement must conduct: one full scale exercise (FSE) typically involves multiple agencies, or disciplines and integrates operational elements (can perform a facility-based exercise to meet) Must conduct any one exercise of choice- individual exercise, tabletop, workshop, or mock drill annually. Exemption: if the facility activates its emergency program due to an actual event/emergency, this would then be sufficient for the community/full scale exercise or individual based exercise. Must show all documentation	the Community Agency meeting which will be held at the community center by year end. Will include City of Cook, EMS, etc. to discuss EP Plans, Contacts, resources, HVA. Currently: 4/23- activated Lockdown r/t threatening caller; involvement with SLC Sheriff's office, and internal response. 6/23 – Crisis Intervention Team drill (Michelle Completed per Safety committee)	
ADDITIONAL TOPICS/QAPI'S				
NEW QAPI's				
Per POC: ADL Assistance Narcotic Ledger Page use Self Admin of Medications Expired Medications		Theresa and Brooklyn continued their audits, and the desk audit was held by MDH in September and found to be in compliance with submitted documents. Theresa reports that the Narcotic Ledger/ index is still not 100% with Pharmacy and nursing recording the medication. She continues to re-educate and work on this process.		
Workplace Violence	Julie/Michelle	Julie updated the team regarding the new requirements with Workplace Violence, an overview of this, including Michelle obtaining instructor certification for MOAB, Stephanie Maki, will also become an instructor and Michelle will roll out the entire program within the next few weeks. Updated the group on the Security pendants status.		

<u>Additional comments/questions or discussion</u>: MDH State Surveyors did enter for a full federal/state recertification survey on 7/10/23 and exited 7/13/23. Desk audit completed the end of September, found to be in compliance.

NEXT MTG: 1/18/24 at 1000- LCR

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PRESENT: Facilitator: Julie Lesemann,
Chris Judas, Theresa Henshaw, Amy Rausch, Amy Kemp, Marge Hyppa (Board); Liz Dahl (Board Chair); Dr. Vidor (Medical Director)