DEPARTMENT OF HEALT						EDICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: COP8
	PARTI	- TO BE COME	PLETED BY	THE STAT	TE SURVEY AGENCY	Facility ID: 00326
1. MEDICARE/MEDICAID PROVID (L1) 245485	DER NO.	3. NAME AND AL (L3) JOHNSON			ME	4. TYPE OF ACTION: 7 (L8)
2.STATE VENDOR OR MEDICAID N	IO	(L4) 1282 WALN				1. Initial 2. Recertification
(L2) 808845402		(L5) DAWSON, 1			(L6) 56232	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEG	ORY	<u>02</u> (L7)	7. On-Site Visit 9. Other
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 08 /	10/2017 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other	r	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED A	AS:		I
From (a):		X A. In Complia	ance With		And/Or Approved Waivers Of The	e Following Requirements:
To (b) :			Requirements		2. Technical Personnel	6. Scope of Services Limit
		Compilar	nce Based On:		3. 24 Hour RN	7. Medical Director
12.Total Facility Beds	56 (L18)	1.	Acceptable POC		4. 7-Day RN (Rural SNF) 8. Patient Room Size
13.Total Certified Beds	56 (L17)	B Not in Co	ompliance with Pro	aram	5. Life Safety Code	9. Beds/Room
15. Total Certified Beds	30 (E17)		and/or Applied W	-	* Code: A*	(L12)
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY MEETS	
18 SNF 18/19 SN	F 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
56						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	1ARKS (IF APPLICABI	E SHOW LTC CANC	ELLATION DAT	E):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY A	APPROVAL Date:
	i		00/01/0017		Challas Districk Cartifi	
Gail Anderson, Unit Supe	ervisor		09/01/2017	(L19)	Shellae Dietrich, Certific	cation Specialist 09/11/2017 (L20)
	PART II - TO BI	E COMPLETED	BY HCFA R	REGIONAL	COFFICE OR SINGLE ST	ATE AGENCY
19. DETERMINATION OF ELIGIBID	LITY		MPLIANCE WITH	I CIVIL	21. 1. Statement of Finan	
X 1. Facility is Eligible to	o Participate	R	IGHTS ACT:		 Ownership/Control Both of the Above 	Interest Disclosure Stmt (HCFA-1513)
 Facility is not Eligi 	-					
	(L21)					
22. ORIGINAL DATE	23. LTC AGREEN	IENT 2	24. LTC AGREE	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DA	TE	VOLUNTARY00	INVOLUNTARY
06/01/1987					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	nt 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS	(-)		03-Risk of Involuntary Termination	OTHER
25. ETC EXTENSION DATE:		n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
			(L44)			00-Active
(L27)	B. Rescind Su	spension Date:				
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL I	DATE	Posted 09/15/2017 Co.	
		08/10/2017				
	(L32)			(L33)	DETERMINATION APPR	OVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245485

August 31, 2017

Ms. Stacey Lee, Administrator Johnson Memorial Hospital & Home 1282 Walnut Street Dawson, MN 56232

Dear Ms. Lee:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective July 30, 2017 the above facility is recommended for:

56 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 56 skilled nursing facility beds. You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions related to this electronic notice.

Sincerely,

Anne Retenson

Licensing and Certification Program Health Regulation Division Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 anne.peterson@state.mn.us Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 1, 2017

Ms. Stacey Lee, Administrator Johnson Memorial Hospital & Home 1282 Walnut Street Dawson, MN 56232

RE: Project Number S5485027

Dear Ms. Lee:

On June 27, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 15, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 10, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 1, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 15, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 30, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 15, 2017, effective July 30, 2017 and therefore remedies outlined in our letter to you dated June 27, 2017, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions regarding this electronic notice.

Sincerely,

Anne Retension -

Licensing and Certification Program Health Regulation Division Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 anne.peterson@state.mn.us Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		DICARE/MEDICA					I	ID: COP8
	PART	I - TO BE COM	PLETED BY TI	HE STAT	E SURVEY A	AGENCY	1	Facility ID: 00326
1. MEDICARE/MEDICAID PROVIDER NO).	3. NAME AND ADD			F		4. TYPE OF ACTION	<u>2</u> (L8)
(L1) 245485		(L3) JOHNSON M		P&HOM	Ł		1. Initial	2. Recertification
2.STATE VENDOR OR MEDICAID NO. (L2) 808845402		(L4) 1282 WALNU			а	.6) 56232	3. Termination 5. Validation	4. CHOW
		(L5) DAWSON, M	111			,	7. On-Site Visit	6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF OWN	ERSHIP	7. PROVIDER/SUP				L7)	8. Full Survey After C	omplaint
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA		• p
6. DATE OF SURVEY 06/15 /2		02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		FISCAL YEAR ENDING	G DATE: (L35)
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	_	09/30	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	2	07/30	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:				1	
From (a):		A. In Complian	ice With		And/Or App	proved Waivers Of The	Following Requirements:	
To (b) :		Program Rec			2. T	Technical Personnel	6. Scope of Serv	vices Limit
		Compliance	Based On:			4 Hour RN	7. Medical Dire	ctor
12. Total Facility Beds	56 (L18)	1. A	cceptable POC		4. 7	-Day RN (Rural SNF)	8. Patient Room	Size
13. Total Certified Beds	56 (L17)	X B Not in Com	pliance with Program		5. L	Life Safety Code	9. Beds/Room	
15. Total Contined Deals		1	and/or Applied Waive		* Code:	B*	(L12)	
14. LTC CERTIFIED BED BREAKDOWN					15. FACILIT	Y MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1)	or 1861 (j) (1):	(L15)	
56								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARKS	S (IF APPLICABLE S	SHOW LTC CANCELL	ATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE S	URVEY AGENCY AP	PROVAL	Date:
Denise Erickson,	<u>, HFE NE II</u>	[(07/10/2017	(L19)	Kate Jo	ohnsTon, Pro	ogram Specialis	<u>st</u> 08/09/2017 (L20)
	PART II - TO	BE COMPLETEI	D BY HCFA RE	GIONAL	OFFICE O	R SINGLE STAT	E AGENCY	
19. DETERMINATION OF ELIGIBILITY			PLIANCE WITH CI	VIL			al Solvency (HCFA-2572)	
1. Facility is Eligible to Parti	cipate	RIGH	ITS ACT:			 Ownership/Control I Both of the Above : 	nterest Disclosure Stmt (HCF	A-1513)
2. Facility is not Eligible								
	(L21)							
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEME	NT	26. TERMIN	NATION ACTION:		(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DATE		VOLUNTARY	<u>Y</u> _00	INVOLUN	TARY
06/01/1987					01-Merger, Cl	losure	05-Fail to M	feet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfac	tion W/ Reimbursemen	nt 06-Fail to N	feet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIV	E SANCTIONS			03-Risk of Inv	oluntary Termination	OTHER	
	A. Suspension	of Admissions:			04-Other Reas	on for Withdrawal	07-Provider	r Status Change
(L27)			(L44)				00-Active	
(127)	B. Rescind Sus	pension Date:						
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARK	KS .		
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION C	OF APPROVAL DAT	Έ				
	(L32)			(L33)	DETERMI	NATION APPRO	VAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 27, 2017

Ms. Stacey Lee, Administrator Johnson Memorial Hospital & Home 1282 Walnut Street Dawson, MN 56232

RE: Project Number S5485027

Dear Ms. Lee:

On June 15, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit; <u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gail Anderson, Unit Supervisor Fergus Falls Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1505 Pebble Lake Road, Suite 300 Fergus Falls, Minnesota 56537-3858 Email: gail.anderson@state.mn.us Phone: (218) 332-5140 Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 25, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 25, 2017 the following remedy will be imposed:

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

Johnson Memorial Hospital & Home June 27, 2017 Page 4

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 15, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original

Johnson Memorial Hospital & Home June 27, 2017 Page 5

statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 15, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

> Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525 Johnson Memorial Hospital & Home June 27, 2017 Page 6 Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: <u>mark.meath@state.mn.us</u> Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0311 MATTERNS FOR MEDICARE & MEDICAID SERVICES (P3) MULTIPLE CONSTRUCTION (P4) MULTIPLE CONSTRUCTION			AND HUMAN SERVICES				FORM	APPROVED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BULDING COMPLETED NAME OF PROVIDER OR SUPPLIER 245485 IN WIND 06/15/2017 JOHNSOM MEMORIAL HOSP & HOME 1282 WALNUT STREET DOMESON, IMI 56232 00/07 JOHNSOM MEMORIAL HOSP & HOME 1282 WALNUT STREET DAME OF PROVIDER OR SUPPLIER 00/07 IPROFINE SUMMARY STREEMENT OF DEFICIENCIES PROVIDER SUP AN OF CORRECTION 00/07 IPROFINE SUMMARY STREEMENT OF DEFICIENCIES PROVIDER SUP AN OF CORRECTION 00/07 IPROFINE SUMMARY STREEMENT OF DEFICIENCIES PROVIDER SUP AN OF CORRECTION 00/07 IPROFINE SUMMARY STREEMENT OF DEFICIENCIES PROVIDER SUP AN OF CORRECTION 00/07 IPROFINE SUMMARY STREEMENT OF DEFICIENCIES PROVIDER SUP AN OF CORRECTION 00/07 IPROFINE SUMMARY STREEMENT OF DEFICIENCIES PROVIDER SUP AN OF CORRECTION 00/07 IPROFINE SUMMARY STREEMENT OF DEFICIENCIES PROVIDER SUP AN OF CORRECTION 00/07 IPROFINE ON JUNE 12.13.14.15.2017. a standard survey was completed at your facility by the Minnesota Department of Health to deformine if your facility was in compliance with requirements of LODY Term Care Facility's and Facility must provide a safe, functional, sa	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	I		0	<u>MB NO.</u>	<u>. 0938-0391</u>
NAME OF PROVIDER OR SUPPLIER OWNED JOHNSON MEMORIAL HOSP & HOME DEFINITION JOHNSON MEMORIAL HOSP & HOME DEVEXPONT Image: Construction of the second state of the secon								
1282 WAUNUT STREET DAWSON, WIS 6623 PROVIDER TO COMPLETION AND STATEMENT OF DEFICIENCIES TAG PROVIDERT STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PHECEBED BY FULL TAG PROVIDERT STATEMENT COMPLETIONCIES (EACH DEFICIENCY MIST BE PHECEBED BY FULL TAG PROVIDERT STATEMENT COMPLETIONCIES (EACH DEFICIENCY MIST BE PHECEBED BY FULL TAG PROVIDERT STATEMENT COMPLETIONCIES (EACH DEFICIENCY MIST BE PHECEBED BY FULL TAG PROVIDERT STATEMENT COMPLETIONCIES (EACH DEFICIENCY MIST BE PHECEBED BY FULL TAG PROVIDERT STAN OF COMPLETION BY UNA STATEMENT (EACH DEFICIENCY MIST BE PHECEBED BY FULL TAG PROVIDERT STAN OF COMPLETION BY UNA STATEMENT (EACH DEFICIENCY MIST BE PHECEBED BY FULL TAG PROVIDERT STAN OF COMPLETION BY UNA STATEMENT (EACH DEFICIENCY MIST BE PHECEBED BY FULL TAG PROVIDERT STAN OF COMPLETION BY UNA STATEMENT (EACH DEFICIENCY MIST BE PHECEBED BY UNA DEFICIENCY PROVIDERT STAN OF COMPLETION BY UNA DEFICIENCY COMPLETION BY UNA DEFICIENCY COMPLETION (EACH DEFICIENCY DEFICIENCY MIST BE PHECEBED BY UNA DEFICIENCY COMPLETION (EACH DEFICIENCY OF COMPLETION BY UNA DEFICIENCY OF COMPLETION BY UNA DEFICIENCY (FICE DIA STATE BY UNA DE COMUCED OF COMPLETION BY UNA DEFICIENCY (FICE DIA STATE BY UNA DE COMUCED OF COMPLETION BY UNA DEFICIENCY (FICE DIA STATE BY UNA DE COMUCED OF DEFICIENCY OF COMPLETION BY UNA DEFICIENCY (FICE DIA STATE BY UNA DE COMUCED OF COMPLETION BY UNA DEFICIENCY (FICE DIA STATE BY UNA DE COMUCED OF COMPLETION BY UNA DEFICIENCY (FICE DIA STATE BY UNA DE COMUCED OF COMPLETION BY UNA DEFICIENCY (FICE DIA STATE BY UNA DE COMUCED OF COMPLETION BY UNA DEFICIENCY (FICE DIA STATE BY UNA DE COMUCED OF COMPLETION BY UNA DEFICIENCY (FICE DIA STATE BY UNA DE COMUCED OF COMPLETION BY UNA DEFICIENCY (FICE DIA STATE BY UNA DE COMUCED OF COMPLETION BY			245485	B. WING			06/	15/2017
JOHNSON MEMORIAL HOSP & HOME DAWSON, MN 56232 Image: Constraint of the proceeding of the proceeding of the constraint of the proceeding of the constraint of the proceeding of the proceedin	NAME OF F	PROVIDER OR SUPPLIER	·					
PHEFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PRÉFIX TAG (EACH CORRECTIVA CRISCION SHOULD BE CROSS-REFERENCED TO THE APROPRIATE DEFICIENCY) COMPLETION DEFICIENCY F 000 INITIAL COMMENTS F 000 On June 12,13,14, 15, 2017, a standard survey was compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements of 42 CFR Part 483, Subpart B, and Requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facility's plan of correction (POC) will serve as your allegation of compliance upon the Department of the first page of the CMS-2657 form. Your electronic submission of the POC will be used as verification of compliance. F 465 7/25/17 F 465 SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON F 465 7/25/17 SS-EE SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON F 465 7/25/17 (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comotrable environment for residents, staff and the public. F 465 7/25/17 (j) Stabilish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking residents. This REQUIREMENT is not met as evidenced by. The Exerciter SUPRECTORS OF PROVIDERSUPPLER REPRESENTATIVES SIGNATURE THE X0 DEF	JOHNSO	N MEMORIAL HOSP	& HOME					
On June 12,13,14, 15, 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve asyour allegation of compliance upon the readirement's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. F 465 7/25/17 F 465 483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABL ENVIRON F 465 7/25/17 (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. F 465 7/25/17 (i) Stablieh policies, in accordance with applicable Federal, Stake, and local laws and regulations, regarding smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by. The facility must provide a safe, functional, sanitary, and comfortable environment for residents. This REQUIREMENT is not met as evidenced by. The facility must provide take into account non-smoking residents. This REQUIREMENT is not met as evidenced by. The tacility acceptation and account non-smoking residents. The facility acceptation of the account non-smoking residents. The facility must provide a safe, functional, sanitary, and comfortable environment for residents. The facility must provide take into account non-smoking residents. The facility	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETION
was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. Image: Completed to the completed t	F 000	INITIAL COMMENT	rs	F 0	00			
	SS=E	was completed at y Department of Hea was in compliance Part 483, Subpart E Term Care Facilities The facility's plan o as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of you validate that substat regulations has bee your verification. 483.90(i)(5) SAFE/FUNCTIONA E ENVIRON (i) Other Environme The facility must pre- sanitary, and comfor residents, staff and (5) Establish policie applicable Federal, regulations, regardia and smoking safety non-smoking reside This REQUIREMEN	our facility by the Minnesota Ith to determine if your facility with requirements of 42 CFR 3, and Requirements for Long s. f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance. acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with AL/SANITARY/COMFORTABL ental Conditions ovide a safe, functional, ortable environment for the public. es, in accordance with State, and local laws and ing smoking, smoking areas, or that also take into account ents. NT is not met as evidenced		65			
			JEN/OUPPLIER REPRESENTATIVE'S SIGI	NATURE		IIILE		07/06/2017

Electronically Signed

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.

PRINTED: 07/10/2017

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES	1			MB NO.	APPROVEE 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245485	B. WING			06 /1	5/2017
NAME OF I	PROVIDER OR SUPPLIER	•	•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
JOHNSC	ON MEMORIAL HOSP	& HOME			82 WALNUT STREET AWSON, MN 56232		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	Based on observat failed to provide ho services necessary sanitary conditions 1, Rm 25, Rm 30, F 37) reviewed during	tion and interview the facility usekeeping and maintenance to maintain functional, for 8 of 8 resident rooms (Rm Rm 33, Rm 34, Rm 35, Rm g the environmental tour. This ad the potential to affect all	F 4	465	We are a tobacco free campus. Th policy has been in place since 1996 All issues found in the rooms listed corrected on or before 7/25/2017.	j.	
	Findings include: On 6/14/17, at 1:04 p.m. an environmental tour of the facility was conducted with the maintenance supervisor (MS) present. The MS confirmed the following findings during				Environmental Services Manager with the assistance of maintenance staff will inspect all others rooms the week of 7/10-7/14 for any similar issues and will be resolved by 7/25/17 if any are found. RM 1 - Door will be sanded and touched up. Wall will be repaired and repainted.		
	scraped up, missir (ft) across the midd wall next to the bath had peeling/chippin 1 ft x 2 ft. -Room 25, the bath heavy white/green	en bathroom door was ng varnish, measuring 3 feet lle of the entire door and the hroom door on the right side ng paint and plaster measuring proom faucet in the sink had a lime scale buildup on the			RM 25- The faucet will be cleaned or replaced if needed. Will replace can to fix the leak. RM 30- The faucet will be cleaned or replaced if needed. Will replace can to fix the leak.	tridges or	
	was leaking water. -Room 30, the bath heavy white/green handles, the base of drain and was leaking -Room 33, the bath heavy white/green handles and the ba	se of the faucet hardware and froom faucet in the sink had a lime scale buildup on the of the faucet hardware, and ing water. Froom faucet in the sink had a lime scale buildup on the se of the faucet hardware and Multiple dark, discolored black			RM 33- The faucet will be cleaned or replaced if needed. Will replace car to fix the leak. The floor will be scru to eliminate stains (replace if neede RM 34- Walls will be repaired and repainted. RM 35- Caulk around the toilet base be removed, the area cleaned, then recaulked.	tridges bbed ed). e will	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00326

		AND HUMAN SERVICES			FORM	07/10/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		E SURVEY PLETED
		245485	B. WING _		06/	15/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	-	
JOHNSO	N MEMORIAL HOSP	& HOME		1282 WALNUT STREET DAWSON, MN 56232		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 465	and toilet area. -Room 34, the bath and left side of toile was noted to have entire length of the -Room 35, the bath the toilet was noted matter and was sta -Room 37, the bath on the inside of the off on the lower left	e floor by the bathroom sink proom walls on the right of sink at when entering the bathroom black scuff marks across the walls. proom, the entire base around to have dark brown/black ined. proom, the kick plate and wood bathroom door was coming bottom corner and was turned	F 4	RM 37- Will remove sha plate and replace if need There will be a checklist to fill out while doing the "Paths oCheck that the path tripping hazards(no elect cords, etc). "Furniture oCheck bed operatio oCheck furniture fu properly(recliner, lift cha sure it s stable.	ded. t for housekeeping ir daily cleaning. hways are clear of strical cord, call n unctions	
	repaired issues wh base system and s that needed to be f indicated his staff v been reported and fixed. The MS indi- routine room or fac staff to report issued did not know about above and stated "v reported back to m MS indicated he fel and thought they co make repairs in the On 6/14/17, the re	ic p.m. MS indicated he ich were reported on his web taff would report these issues ixed in the building. The MS would fix the issues that had sign off when the issues were cated he did not conduct ility inspections and relied on es to him. The MS indicated he the needed repairs listed correct stuff is not getting e, so it's not getting fixed." The It things were getting neglected build have a better system to e facility.		 Lighting Replace burned out bulbs. Check operation of damaged cords). Flooring Clean, Repair or Recovering. Replace high, broke thresholds. Doors Check for proper fu Check for scratches plates. Walls Checks walls for ho anything that may need repainted. Bathrooms Check for loose har Check sink and sinh build-up. Check tor leak 	call light(replace eplace floor en or missing nction. s, loose kick les, scratches, to be fixed and ndrails c fixtures for leaks.	

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Facility ID: 00326

If continuation sheet Page 3 of 4

		AND HUMAN SERVICES			FORM	07/10/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245485	B. WING _		06/	15/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
JOHNSC	N MEMORIAL HOSP	& HOME		1282 WALNUT STREET DAWSON, MN 56232		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	LD BE	(X5) COMPLETION DATE
F 465	Continued From pa	age 3	F 4		e room of these custodian De eir next Manager o ensure leted. r QA. y QA will be eeting on kly s for a	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00326

If continuation sheet Page 4 of 4

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CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES			OMB NO. 0938-039	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		241314	B. WING		05/03/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1282 WALNUT STREET DAWSON, MN 56232		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
K 000	INITIAL COMMEN	TS	K 00	0		
	FIRE SAFETY			ROVED Thomas R. Le		
•	Minnesota Departr Fire Marshal Divisi Johnson Memorial compliance with th In Medicare/Medic 485.623(d), Life Sa edition of National (NFPA) Standard Chapter 19 Existin edition of NFPA 99 PLEASE RETURN CORRECTION FC DEFICIENCIES (K Health Care Fire In State Fire Marshal 444 Cedar St., Sui St Paul, MN 5510 Or by e-mail to: Marian.Whitney@a and Angela.kappenma	nent of Public Safety, State on. At the time of this survey, Hospital was found not in e requirements for participation aid at 42 CFR, Subpart afety from Fire, and the 2012 Fire Protection Association 101, Life Safety Code (LSC), g Health Care and the 2012 b, Health Care Facilities Code. THE PLAN OF DR THE FIRE SAFETY (-TAGS) TO: Inspections Division te 145 1-5145, state.mn.us DRRECTION FOR EACH ST INCLUDE ALL OF THE		h Linhoff at 3:16 pm, Jun	15, 2017	
	1. A description of to correct the defic	what has been, or will be, done ciency.				
LABORATO	I - integras / //	DER/SUPPILIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE	
St	2/ ///			CEO tulion may be excused from correcting prov	6-15-17	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is definitive 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		241314	B. WING		05/03/	2017
	PROVIDER OR SUPPLIER	ITAL	1	STREET ADDRESS, CITY, STATE, ZIP CODE 282 WALNUT STREET DAWSON, MN 56232		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		(X6) DMPLETION DATE
K 000	Continued From pa	age 1	K 000			
	2. The actual, or pr	oposed, completion date.				
	responsible for cor	r title of the person rection and monitoring to ence of the deficiency.				
	Critical Access Hos without basement. at 3 different times constructed in 197 Type II(111) constru- added that was als II(111). In 2007 an northwest and sout	Hospital is licensed as a spital and is a 1 story building The building was constructed . The original building was 4 and was determined to be of uction. In 1997 an addition was o determined to be of Type addition was added both the in ends of the facility that were f Type II(111) construction.				
	Due to the code ch was surveyed as o	ange July 5, 2016 the facility ne building.	-		~	
	sprinkler system. T	ected by a complete fire he facility has a fire alarm detection that is monitored for intment notification.				
	The facility has a d	apacity of 18 certified beds.				
K 321	is NOT MET as evi	: 42 CFR, Subpart 485.623(d) denced by: us Areas - Enclosure	K 321			
	having 1-hour fire r fire rated doors) or	Enclosure re protected by a fire barrler esistance rating (with 3/4-hour an automatic fire extinguishing nce with 8.7.1. When the				
ORM CMS-26	67 (02-99) Previous Versions	Obsolete Event ID: V67G2	1 Fe	acility ID: 00326A If contin	uallon sheet Pr	age 2 of

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
	2	241314	B, WING	1.1.1.1.1.1		05/0	3/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
IOUNEC	N MEMORIAL HOSPI	1761			282 WALNUT STREET		
30/1030				D	DAWSON, MN 56232		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Pref TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) Completio Date
K 321	option is used, the other spaces by sin doors in accordanc self-closing or auto have nonrated or fil that do not exceed the door. Describe the floor a	age 2 c fire extinguishing system areas shall be separated from noke resisting partitions and the with 8.4. Doors shall be matic-closing and permitted to eld-applied protective plates 48 inches from the bottom of and zone locations of nat are deficient in REMARKS.	K	321	K321 The Spring loaded door hinges adjusted to ensure that the doo positively latch. Scott Ochsendorf Facilities Manager	were r would	5-9-17
	b. Laundries (larger c. Repair, Maintena d. Soiled Linen Roo e. Trash Collection (exceeding 64 gallo f. Combustible Stor (over 50 square fee g. Laboratories (lf o Hazard - see K322) This STANDARD I Based on observat facility to maintain a accordance with the (NFPA 101) section condition could allo corridor making it u and efficient exiting	Fired Heater Rooms r than 100 square feet) ance, and Paint Shops oms (exceeding 64 gallons) Rooms ons) rage Rooms/Spaces of) classified as Severe				23	×
	on 05-03-2017 observealed the solled	between 9:00 am to 4:00 pm ervations and staff interview utility room door in the					
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: V87G2	1	Fa	cility ID: 00326A If continu	ation sheet	l Page 3

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING 01 - MAIN BUILDING 01 241314 **B. WING** 05/03/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1282 WALNUT STREET** JOHNSON MEMORIAL HOSPITAL **DAWSON, MN 56232** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID 1D PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE **REGULATORY OR LSC IDENTIFYING INFORMATION)** TAG TAG DEFICIENCY) K 321 **Continued From page 3** K 321 northeast corridor does not positively latch. This deficient condition was confirmed by the Environmental Services Manager, K 341 NFPA 101 Fire Alarm System - Installation K 341 5-8-17 K341 Moved ceiling tiles so that the smoke Fire Alarm System - Installation detector and the heat diffuser are A fire alarm system is installed with systems and over 4' apart components approved for the purpose in accordance with NFPA 70, National Electric Code, Scott Ochsendorf and NFPA 72, National Fire Alarm Code to **Facilities Manager** provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (2012) section 19.3.4.1, 9.6.1.3 and NFPA 72 National Fire Alarm Code (2010) section 17.7.4.1. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect an undetermined amount of patients, staff and visitors. Findings include: Event ID: V67G21

FORM CMS-2587(02-99) Previous Versions Obsolete

Facility ID: 00326A

If continuation sheet Page 4 of 12

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DEPARTMENT OF HEALTH AND HUMAN SERVICES TO FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 · ·	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	241314	B. WING		05/03/2017
NAME OF PROVIDER OR SUF JOHNSON MEMORIAL I	PLIER	STF 126	REET ADDRESS, CITY, STATE, ZIP CODE 12 WALNUT STREET WSON, MN 58232	
PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLET
on 05-03-201 revealed a sn within 36 Inch This deficient Environmenta NFPA 101 Sp Testing Sprinkler Sysi Automatic spi inspected, tes with NFPA 25 Testing, and N Protection Sy- maintenance, maintenance, a) Date sprin b) Who prov	tour between 9:00 am to 4:00 pm 7 observations and staff interview hoke detector in the E.R. corridor is es of a heat diffuser. condition was confirmed by the al Services Manager. rinkler System - Maintenance and tem - Maintenance and Testing rinkler and standpipe systems are sted, and maintained in accordance , Standard for the Inspection, Maintaining of Water-based Fire stems. Records of system design, Inspection and testing are a secure location and readily hkler system last checked	K 341 K 353	K353 Viking Sprinkler was here conducted a 5 year inspec 6-5-17. Scott Ochsendorf Facilities Manager	and otion on
Provide in RE any non-requi system. 9.7.5, 9.7.7, 9 This STANDA Based on obs facility failed t system in acc Code (NFPA The standard sprinkler syste cause the spr	ARRKS Information on coverage for ined or partial automatic sprinkler 7.8, and NFPA 25 RD is not met as evidenced by: servation and staff interview, the o test and maintain the sprinkler ordance with the 2012 Life Safety 101) and NFPA 25 section 5.2.1.1.2. for testing and maintenance of ems. This deficient condition could inkler system not to function allow for the spread of fire. This		5	2

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PRINTED: 05/19/2017

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CENTER		AND HUMAN SERVICES				APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DAT COM	e survey Pleted
		241314	B, WING		05/	03/2017
NAME OF	PROVIDER OR SUPPLIER	Lota (REET ADDRESS, CITY, STATE, ZIP CODE		
JOHNSO	N MEMORIAL HOSPI	TAL	84	82 WALNUT STREET AWSON, MN 56232		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) Completic Date
K 353 K 372	undetermined amor Findings Include: On the facility tour to on 05-03-2017 reco revealed the sprinkly visual obstruction in installation over 5 ye This deficient condi Environmental Serv NFPA 101 Subdivisi Smoke Barrie Subdivision of Build Construction 2012 EXISTING Smoke barriers sha fire resistance rating be permitted to term Smoke dampers are penetrations in fully	e 18 patients and an unt of staff and visitors. Detween 9:00 am to 4:00 pm ord review and staff interview ler system has not had a ispection inspection since its ears ago. tion was confirmed by the vices Manager. ion of Building Spaces - ling Spaces - Smoke Barrier g per 8.5. Smoke barriers shall hinate at an atrium wall. e not required in duct ducted HVAC systems where	K 353	K372 We have purchased materials all penetrations. We will have penetrations corrected by Jul Scott Ochsendorf Facilities Manager	e all	By 7-1-
	smoke compartmer barrier, 19.3.7.3, 8.6.7.1(1) Describe any mecha in REMARKS, This STANDARD is	er system is installed for its adjacent to the smoke anical smoke control system s not met as evidenced by: ion and staff interview the	Tr.			
	facility failed to main required by the 2012 101) section 19.3.7. practice could allow	Itain a smoke barrier as 2 Life Safety Code (NFPA 3, 8.8.7.1 (1). This deficient smoke to transfer from one t to another affecting the				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTER	AS FOR MEDICARE	& MEDICAID SERVICES			0	VID NO.	0930-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	01	(X3) DATE COMP	SURVEY PLETED
		241314	B. WING			05/0	3/2017
	PROVIDER OR SUPPLIER	TAL		STREET ADDRESS, CITY 1282 WALNUT STREE DAWSON, MN 5623	т		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROP DEFICIENCY)	BE	(X5) Completion Date
K 372	Findings Include: On the facility tour I on 05-03-2017 obsi- revealed penetratio stopping above the adjacent to the clini 1. A 3x3 on the cor 2. A pipe penetratio break room, above 3. A 3x3 on the cor the radiology door. 4. A 1 inch open ho the west office. 5. A cable bundle of cross corridor door 6. A pipe penetratio	between 9:00 am to 4:00 pm ervations and staff interview ns without the proper fire ceiling of the smoke barrier c in the following areas. ridor side next to the east exit. on on the room side of the the door. ridor side on the left side of ble on the corridor side next to on the south side of the west s.	K 37	72			
	Environmental Serv NFPA 101 Fire Drills Fire Drills Fire drills Include th signal and simulatic conditions. Fire drill times under varying on each shift. The s and is aware that du routine. Responsibil conducting drills is a persons who are qu Where drills are con 6:00 AM, a coded a instead of audible a	tion was confirmed by the vices Manager. s e transmission of a fire alarm on of emergency fire s are held at unexpected conditions, at least quarterly staff is familiar with procedures vills are part of established lity for planning and assigned only to competent valified to exercise leadership. Inducted between 9:00 PM and nnouncement may be used	K 7'	Going forward badge number calling in to ge alarm was rec	, I will get the nan r from the operato et confirmation tha eived. tt Ochsendorf ilities Manager	r when	5-4-17
ORM CMS-260	37(02-00) Previous Versions	Obsolete Event ID: V67G21	w	Pacility ID: 00326A	lf continue	ation sheet	Page 7 of 12

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		241314	8. WING			05/0	3/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
JOHNSO	N MEMORIAL HOSPI	TAL			282 WALNUT STREET DAWSON, MN 56232		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Pref Tag		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEF(CIENCY)	BE	(X5) Completion Date
K 712	19.7.1.7 This STANDARD is Based on record re facility failed to provalarm transmission required required b 101) 2012 edition, s This deficient practistaff to conduct a sifire emergency, whi and an undetermine Findings include: On the facility tour to on 05-03-2017 recorrevealed the fire dri integrity of the alarm This deficient condi Environmental Serv NFPA 101 Portable Portable Space Hea Portable Space Hea Portable Space hea prohibited in all hea unless used in non- areas where the he 212 degrees Fahren 18.7.8, 19.7.8 This STANDARD is Based on record re interview the facility policy for the use of they met the require edition of the Life Si- section 19.7.8. This	s not met as evidenced by: aview and staff interview the vide documentation of the on the fire drills reports as y the Life Safety Code (NFPA section 19.7.1.4 to 19.7.1.7. ice could reduce the ability of afe and timely response to a ich would affect all 18 patients ad amount of staff and visitors.		712		heater	6-7-17

FORM CMS-2607(02-99) Previous Versions Obsolete

Facility ID: 00328A

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If continuation sheet Page 8 of 12

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	of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		241314	8. WING		05/03/2017
	PROVIDER OR SUPPLIER	TAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1282 WALNUT STREET DAWSON, MN 55232	
(X4) ID PREFJX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLETION
K 781	Continued From pa	ge 8	K 7	81	
	On the facility tour l on 05-03-2017 reco staff interview revea heaters were being reception area and without a policy in p	tions was confirmed by the		Requesting Temp Waiver	
K 916	NFPA 101 Electrical Syste Electrical Systems - Alarm Annunciator A remote annunciator powered is provided generating room in operating personne hard-wired to indica emergency power s system (e.g., buildin to be substituted for 6.4.1.1.17, 6.4.1.1.1 This STANDARD is Based on observat facility failed to insta the generator as rea Facilities Code 2012 6.4.1.1.17.5. This di for the generator to	I Systems - Essential Electric - Essential Electric System or that is storage battery d to operate outside of the a location readily observed by I. The annunciator is te alarm conditions of the ource. A centralized computer ng information system) is not the alarm annunciator.	Κ9	16 K916 We will be getting a new gene upcoming building renovation, generator remote annunciator added at this time. Scott Ochsendorf Facilities Manager	The
	patients, staff and v Findings include:	191(919,			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIFLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01 (X3) DATE SUR COMPLETE A BUILDING 01 - MAIN BUILDING 01 NAME OF PROVIDER OR SUPPLIER JOHNSON MEMORIAL HOSPITAL STREET ADDRESS, CITY, STATE, ZIP CODE 1282 WALNUT STREET DAWSON, MN 86232 05/03/20 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COM K 916 Continued From page 9 On the facility tour between 9:00 am to 4:00 pm on 05-03-2017 observations and staff interview revealed there was no generator remote annunciator. K 916 K 916 K 916 K 916	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			Ő	MB NO.	0938-039
MAKE OF PROVIDER OR SUPPLIER STREET ADDRESS, GTY, STATE, 2/P CODE JOHNSON MEMORIAL HOSPITAL STREET ADDRESS, GTY, STATE, 2/P CODE JOHNSON MEMORIAL HOSPITAL DAWSON, MWN 65232 PARTY REGULATORY OR LSC DENTFYING INFORMATION) PREVEX YAG PROVER'S PLAN OF CORRECTION PROVER'S PLAN OF CORRECTION YAG On the facility bour between 9:00 am to 4:00 pm on 05-03-2017 observations and staff interview revealed there was no generator remote annunciator. K 918 This deficient condition was confirmed by the Environmental Services Manager. K 918 The generator or other alternate power source and associated equipment is capabile of supplying service within 10 seconds. If the 10-second criterion is not met during the monthily test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 101. Scott Ochsendorf Facilities Manager Maintenance and testing of the generator and transfer switches are inspected weakly, exarcised under locad 30 minutes 12 times a year in 20-40 day intervals, and exercised on every 36 months for 4 actificies Induste a completed simulated cold start and automatic or manual transfer of all EES leads, and are conduced by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 110. Maintenance and testing of the actual weakled according to manufacturer requirements. Written records of maintenance and teststing of the genesite annually, and a program f	STATEMEN	r of deficiencies	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVE COMPLETED	
JOHNSON MEMORIAL HOSPITAL 1282 WALNUT STREET DAWSON, NM 56232 PREFX TAG SUMMARY GRATEMENT OF DEPROFENCIES (EACH DEFCIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PREFX TAG PREFX TAG K 916 Continued From page 9 On the facility tour between 9:00 am to 4:00 pm on 05-03-2017 observations and tatif Interview revealed there was no generator remote annunciator. K 918 K 918 K 918 Continued From page 9 On the facility tour between 9:00 am to 4:00 pm on 05-03-2017 observations and tatif Interview revealed there was no generator remote annunciator. K 918 K 918 K 918 NFPA 101 Ellectrical Systems - Essential Electric Syste K 918 K 918 Electrical Systems - Essential Electric Syste K 918 K 918 Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second orther in is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and ortical branches. Maintenance and testing of the generator and transfer switches are parformed in accordance with NFPA 110. Mein and feeder under foad 20 minutes 12 times a eyear in 20-40 day intervals, and exercised once avery 36 months for 4 continuous hours. Scheduled test under foad conditions include a complete simulated oold stat and automatic or manual transfer of all EES leads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 110. Main and feeder chrout breakers are hispected mully, and a program for periodically exercising the componentis is satabili			241314	B, WING			05/0	3/2017
JOHNSON MEMORIAL HOSPITAL DAWSON, MN 56232 (x) (i) (EACH DEFICIENCE WIST BE PROFILE OF DEFICIENCIES (EACH DEFICIENCY WIST BE PROFILE OF DEFICIENCIES (EACH DEFICIENCY WIST BE PROFILE OF DEFICIENCIES) (EACH DEFICIENCY WIST BE PROFILE OF DEFICIENCY TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WIST BE PROFILE) (EACH DEFICIENCY WIST BE PROFILE OF DEFICIENCY On the facility four between 9:00 am to 4:00 pm on 05-03-2017 observations and staff interview revealed there was no generator remote annunclator. K 918 K 918 This deficient condition was confirmed by the Environmental Services Manager. K 918 K 918 YFR N 101 Electrical Systems - Essential Electric Syste K 918 K 918 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the lies safety and oritical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator set are inspected weakly, exercised under load conditions Include a complete simulated cold start and automatific or manual transfer of all EES loads, and are conducted by completent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected apanually,	NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
Column PREFix Summary statement of pericencies Interview (Each Dericency Must be PRECEDED by FULL (Each Content each each each each each each each each	JOHNSO		37A)					
PREFIX TAG CECH DEFICIENCY MOT BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) PREFIX TAG CECH CORRECTVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY CECH CORRECTVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY CM K 916 Continued From page 9 On the facility four between 9:00 am to 4:00 pm on 05-03-2017 observations and staff interview revealed there was no generator remote annunciator. K 918 K 918 This deficient condition was confirmed by the Environmental Services Manager. K 918 K 918 VFPA 101 Electrical Systems - Essential Electric Syste K 918 K 918 Include the 30% load test requirements capability for the ife safety and critical branches. Maintenance and testing The generator or other alternate power source and associated equipment is capable of supplying gervice within 10 seconds. If the 10-second criterion is not met during the monthy test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weakly, exercised under load conditions holucia a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder chrcuit breakers are inspected annually, and a program for periodically exercising the components is estabilished according to manufacturer requirements. Written records of maintenance and testing are mainitainded and readily available. EES electrical panels	JOHNSC					DAWSON, MN 56232		
On the facility tour between 9:00 am to 4:00 pm on 05-03-2017 observations and staff interview revealed there was no generator remote annunciator. K 918 This deficient condition was confirmed by the Environmental Services Manager. K 918 NFPA 101 Electrical Systems - Essential Electric Syste K 918 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Scott Ochsendorf Facilities Manager Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load 30 minutes a conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readity available. EES electrical panels and	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	(X5) Completion Date
 Environmental Services Manager. K 918 NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load s0 minutes 12 times a year in 20-40 day intervals, and exercised once and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing of each annually. And a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing and and readily available. EES electrical panels and 	K 916	On the facility tour l on 05-03-2017 obs revealed there was annunciator.	between 9:00 am to 4:00 pm ervations and staff interview no generator remote	K	916	3		
Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load start and automatic or manual transfer of all EES loads, and are conducted by competent personnet. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panets and	K 918	Environmental Serv NFPA 101 Electrica Syste	vices Manager. I Systems - Essential Electric	K	918	I revised the monthly generator		5-11-17
under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnet. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and		Maintenance and To The generator or ot and associated equ service within 10 se criterion is not met process shall be pro capability for the life Maintenance and te transfer switches an with NFPA 110.	esting her alternate power source lipment is capable of supplying conds. If the 10-second during the monthly test, a ovided to annually confirm this a safety and critical branches. osting of the generator and re performed in accordance			Scott Ochsendorf		×
		under load 30 minu day intervals, and e months for 4 contin- under load condition simulated cold start transfer of all EES I competent personn stored energy powe accordance with NF circuit breakers are program for periodic components is esta manufacturer requir maintenance and te	tes 12 times a year in 20-40 xercised once every 36 uous hours. Scheduled test as include a complete and automatic or manual oads, and are conducted by el. Maintenance and testing of r sources (Type 3 EES) are in PA 111. Main and feeder inspected annually, and a cally exercising the blished according to rements. Written records of esting are maintained and					
RM CMS-2667(02-99) Previous Versions Obsolete Event ID: V67G21 Facility ID: 00326A If continuation sheet Page		circuits are marked	and readily identifiable.					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	f of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION D1 - MAIN BUILDING 01		TE SURVEY MPLETED
		241314	B. WING		05	/03/2017
	PROVIDER OR SUPPLIER ON MEMORIAL HOSPI	ITAL	1	TREET ADDRESS, CITY, STATE, ZIP C 282 WALNUT STREET AWSON, MN 56232	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X6) COMPLETIO DATE
K 918	Minimizing the pose emergency power s consideration for ne 6.4.4, 6.5.4, 6.6.4 (I 111, 700.10 (NFPA This STANDARD I: Based on record re facility falled to prov accordance with the Safety Code (NFPA 2010 edition of NFF Emergency and Sta deficient practice of patients and an unc	sibility of damage of the source is a design aw installations. NFPA 99), NFPA 110, NFPA 70) s not met as evidenced by: aview and staff interview the vide test documentation in a 2012 edition of the Life A 101) section 9.1.3.1 and the PA 110 the Standard for andby Power Systems. This build affect the safety of all 18 determined amount of staff enerator failed to operate	K 918		۲	
K 920	on 05-03-2017 reco revealed the month address the require This deficient condi Environmental Serv NFPA 101 Electrica and Extens Electrical Equipmen Extension Cords Power strips in a pa used for componen patient-care-related (PCREE) assemble by qualified personn 10.2.3.6. Power str	tion was confirmed by the vices Manager. I Equipment - Power Cords at - Power Cords and tient care vicinity are only	K 920			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUM		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVE COMPLETED	
		241314	B. WING		•	05/	03/2017
	PROVIDER OR SUPPLIER	TAL.		STREET ADDR 1282 WALNU DAWSON, M		•••f•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Tement of Deficiencies 'Must be preceded by Full SC Identify!Ng Information}	id Prefi Tag	(EAC	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOUL -REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X6) COMPLETION DATE
K 920	electronics), except rooms that do not u PCREE meet UL 13 strips for non-PCRE (outside of vicinity) i care rooms, power standards. All power precautions. Exten- substitute for fixed v Extension cords use immediately upon c which it was installe 10.2.4. 10.2.3.6 (NFPA 99), (NFPA 70), 590.3(D This STANDARD is Based on observati facility failed to ensu are in accordance w 99 section 10.24.2 strips comply with 1 could affect and an patients, staff and vi Findings include: On the facility tour b on 05-03-2017 obse revealed a power stin north wing of the hor chargers plugged in amperage limit and cord was being used permanent wiring.	in long-term care resident se PCREE. Power strips for 363A or UL 60601-1. Power EE in the patient care rooms meet UL 1363. In non-patient strips meet other UL er strips are used with general sion cords are not used as a wiring of a structure. ad temporarily are removed completion of the purpose for d and meets the conditions of 10.2.4 (NFPA 99), 400-8) (NFPA 70), TIA 12-5 in on met as evidenced by: ion and staff interview the are multiple outlet adapters with the 2012 edition of NFPA. 1 and the use of power 0.2.3.6. This deficient practice undetermined amount of sitors.	K 9	electricia	ms will be fixed by an n (Muth Electric) by July Scott Ochsendorf Facilities Manager	(1, 2017	By 7-1-17

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