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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OTZJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00326

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245485**
2.STATE VENDOR OR MEDICAID NO.
(L2) **808845402**

3. NAME AND ADDRESS OF FACILITY
(L3) **JOHNSON MEMORIAL HOSP & HOME**
(L4) **1282 WALNUT STREET**
(L5) **DAWSON, MN** (L6) **56232**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/25/2015** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **56** (L18)

13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 10/08/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/08/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
06/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/11/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245485

October 8, 2015

Ms. Kathy Johnson, Administrator
Johnson Memorial Hosp & Home
1282 Walnut Street
Dawson, MN 56232

Dear Ms. Johnson:

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 August 14, 2015, the above facility is certified 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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 1, 2015

Ms. Kathy Johnson, Administrator
Johnson Memorial Hospital & Home
1282 Walnut Street
Dawson, Minnesota 56232

RE: Project Number S5485025

Dear Ms. Johnson:

On July 16, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 1, 2015. 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 25, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 31, 2015 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 July 1, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 14, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 1, 2015, effective August 14, 2015 and therefore remedies outlined in our letter to you dated July 16, 2015, 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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245485	A. Building B. Wing	8/25/2015

Name of Facility	Street Address, City, State, Zip Code
JOHNSON MEMORIAL HOSP & HOME	1282 WALNUT STREET DAWSON, MN 56232

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **08/14/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **08/14/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **08/14/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **08/01/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GA/mm	09/01/2015	28034	08/25/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/1/2015			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245485	A. Building B. Wing **01 - MAIN BUILDING 01**	7/31/2015

Name of Facility	Street Address, City, State, Zip Code
JOHNSON MEMORIAL HOSP & HOME	1282 WALNUT STREET DAWSON, MN 56232

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **07/28/2015**	ID Prefix	Correction Completed **07/30/2015**	ID Prefix	Correction Completed **07/06/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0027		LSC K0056		LSC K0144	
ID Prefix	Correction Completed **07/16/2015**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0147		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GS/mm	09/01/2015	34764	07/31/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/30/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: OTZJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00326

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245485**

2.STATE VENDOR OR MEDICAID NO.
(L2) **808845402**

3. NAME AND ADDRESS OF FACILITY
(L3) **JOHNSON MEMORIAL HOSP & HOME**
(L4) **1282 WALNUT STREET**
(L5) **DAWSON, MN** (L6) **56232**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/01/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **56** (L18)

13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Miriam Thornquist, HFE NEII — 08/11/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 08/11/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
06/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

July 16, 2015

Ms. Kathy Johnson, Administrator
Johnson Memorial Hospital & Home
1282 Walnut Street
Dawson, Minnesota 56232

RE: Project Number S5485025

Dear Ms. Johnson:

On July 1, 2015, 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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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:

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

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

Remedies - 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;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - 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
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 August 10, 2015, 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 August 10, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (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.

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 October 1, 2015 (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 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 January 1, 2016 (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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us

Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245485	A. BUILDING _____ B. WING _____	07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MEMORIAL HOSP & HOME	1282 WALNUT STREET DAWSON, MN 56232

(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department'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. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		8/14/15

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

Electronically Signed | 07/23/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245485	A. BUILDING _____ B. WING _____	07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MEMORIAL HOSP & HOME	1282 WALNUT STREET DAWSON, MN 56232

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F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the State agency (SA), and thoroughly investigate an injury of unknown origin for 1 of 1 residents (R59) reviewed for abuse/neglect. Findings include: R59's admission Minimum Data Set (MDS) dated 3/26/15 identified R59 had diagnoses which included; cerebrovascular accident (CVA-stroke), hemiplegia (paralysis) or hemiparesis (weakness) and depression. The MDS identified R59 had moderate cognitive impairment and required extensive assistance from staff to complete all ADL's. R59's care plan (CP) dated 4/1/15 identified R59 had cognitive loss/dementia related to CVA, right sided hemiparesis, dysarthria (difficulty speaking), anxiety, depression and pain. CP also	F 225	Resident R59: Facility will report any further unwitnessed falls with an injury of unknown origin to the Minnesota Department of Health, the Minnesota Adult Abuse Reporting Center, and follow the Incidents or injuries of unknown origin and potential V.A. policy. Other Residents: There were no other residents affected. Facility will report any further unwitnessed falls with an injury of unknown origin to the Minnesota Department of Health, the Minnesota Adult Abuse Reporting Center, and follow the Incidents or injuries of unknown origin and potential V.A. policy. Systemic Changes: Current incident report was revised to include the question, "unwitnessed fall with an extensive injury (required treatment from the provider such as fracture, sutures, dressings, etc.)? Check	

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F 225	Continued From page 2 identified R59 had short term memory loss, required assistance with daily decision making, had weakness, impaired balance and mobility, poor judgement,and difficulty communicating. Further, the CP identified R59 was resistive to cares with kicking or hitting, restless, and was unable to verbally express her wants or needs. Review of a facility incident report dated 5/9/15 at 5:30 p.m. revealed R59 had been found alone in her bathroom, lying on her right side on the floor. R59 had removed her top half of her clothes, and the clip alarm had not sounded. R59 was crying, her right eye swollen shut, and nose swollen and bleeding. R59 was protecting her right arm and shoulder and had a skin tear to right forearm and a bruise on her elbow. The report further indicated there were no witnesses to the incident, the resident room door had been shut, and R59's wheelchair had been found in her room. The report indicated R59 had been found on the floor after staff investigated the closed door, staff had been busy getting people to the dining room with no explanation of how there fall occurred. R59 had received follow up medical evaluation and had been diagnosed with a right clavicle fracture. The report identified various persons had been notified of the injury, however the report did not identify the administrator had been immediately notified of the injury of unknown origin. On 06/29/15, at 3:07 p.m. during interview, the director of nurses (DON) confirmed R59's injury of unknown origin on 5/9/15 had not been reported to the SA. On 06/30/15, at 1:34 p.m., during interview, social services (SS)-A stated, "All of us are responsible and required to report incidents of VA to the SA.	F 225	yes or no. If yes, can the resident tell you what happened? Check yes or no. If no, submit VA report and investigate incident - follow checklist for VA." Added injury of unknown origin algorithm to policy #23.12 and will educate all staff on how to use the algorithm. Injuries of Unknown Origin and potential VA policy will be reviewed with all staff. Staff will be re-educated on injuries of unknown origin for both fall related situations as well as situations that may not be fall related (i.e. bruise or injury of unknown origin noted in a suspicious area like the groin or inner thighs, etc¿). Monitor: All incident reports will be reviewed at the daily IDT meeting and every incident report will be audited by the DON/ADON for appropriate VA reporting. Revise incident report to add "audited for VA" at the bottom by DON signature to check off after audit is completed. The audits will be reviewed at the quarterly QA meetings and department meetings. Audits will be done for every incident report and recorded for auditing for 6 months, but will continue to monitor thereafter. Completion Date: August 14, 2015	

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F 225	Continued From page 3	F 225		

SS-A further stated the VA reporting is so broad, and a fall would be reported depending on the nurse and if their care plan was followed or it could have been prevented. SS-A stated it all depends on the circumstances if an incident would be reported or not. We go through the incident reports in the morning meetings. SS-A confirmed R59 had short term memory loss, disorganized thinking, lethargy, difficulty focusing, and had broken her clavicle after the unwitnessed fall. She confirmed the incident had not been reported to the SA. She further indicated she was not aware why the incident had not been reported and she felt the care plan must have been followed. She stated if they felt they could explain what happed to R59, so they had not reported the incident.

On 06/30/15, at 2:22 p.m. during interview, the assistant director of nursing (ADON) and director of nursing (DON) confirmed the unwitnessed fall with injury for R59 on 5/9/15. The ADON stated she felt R59's care plan had been followed at the time of the incident and indicated the usual facility practice was to report if the resident had died after the fall. DON stated " Its the investigation we do that will determine if its reportable or not, if its not blatantly obvious."

The facility policy titled, Vulnerable Adult Abuse Prohibition Plan, dated 4/2015 defined the following: "Injuries of unknown source"- An injury should be classified as an "injury of unknown source" when both of the following conditions are met:
a. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and,
b. the injury is suspicious because of the extent of

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F 225	Continued From page 4 the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. Further, the facility policy directed to immediately report to the administrator and director of nursing and identified any suspected or observed incidents of abuse or neglect would be immediately reported to the state agency. The policy directed a complete investigation to be done of the incident and documented. On 7/1/15, at 8:36 a.m., the facility administrator confirmed the current facility policy and confirmed R59 had a unwitnessed fall with injuries which included a fractured clavicle. She indicated she did not feel the injury of unknown origin for R59 was a reportable incident.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement the facility vulnerable adult policy regarding reporting to the State agency(SA), conducting a thorough investigation for 1 of 1 resident, (R59) with injury of unknown origin.	F 226	Resident R59: Facility will report any further unwitnessed falls with an injury of unknown origin to the Minnesota Department of Health, the Minnesota Adult Abuse Reporting Center, and follow the "Incidents or injuries of	8/14/15

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F 226	Continued From page 5 Findings include: The facility policy titled, Vulnerable Adult Abuse Prohibition Plan, dated 4/2015 defined the following: "Injuries of unknown source"- An injury should be classified as an "injury of unknown source" when both of the following conditions are met: a. The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and, b. the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. Further, the facility policy directed to immediately report to the administrator and director of nursing and identified any suspected or observed incidents of abuse or neglect would be immediately reported to the state agency. The policy directed a complete investigation to be done of the incident and documented. R59's admission Minimum Data Set (MDS) dated 3/26/15 identified R59 had diagnoses which included; cerebrovascular accident (CVA-stroke), hemiplegia (paralysis) or hemiparesis (weakness) and depression. The MDS identified R59 had moderate cognitive impairment and required extensive assistance from staff to complete all ADL's. R59's care plan (CP) dated 4/1/15 identified R59 had cognitive loss/dementia related to CVA, right sided hemiparesis, dysarthria (difficulty speaking), anxiety, depression and pain. CP also	F 226	unknown origin and potential V.A." policy. Other Residents: There were no other residents affected. Facility will report any further unwitnessed falls with an injury of unknown origin to the Minnesota Department of Health, the Minnesota Adult Abuse Reporting Center, and follow the "Incidents or injuries of unknown origin and potential V.A." olicy. Informal education given on the day of state exit to the charge nurses and primary nurses. Systemic Changes: Current incident report was revised to include the question, "nwitnessed fall with an extensive injury (required treatment from the provider such as fracture, sutures, dressings, etc.)? Check yes or no. If yes, can the resident tell you what happened? Check yes or no. If no, submit VA report and investigate incident - follow checklist for VA. Added injury of unknown origin algorithm to policy #23.12 and will educate all staff on how to use the algorithm. New employees will receive VA training and reporting upon hire through healthcare academy and VA training information sheet from social worker. VA training information sheet will be updated to include injuries of unknown origin. Education will be provided to current employees at the August department meeting regarding the Vulnerable Adult Abuse Prohibition Plan policy and the Incidents or injuries of unknown origin and potential VA policy. Injuries of Unknown Origin and potential VA policy will be reviewed with all staff. Staff will be re-educated on injuries of unknown origin	

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F 226	Continued From page 6 identified R59 had short term memory loss, required assistance with daily decision making, had weakness, impaired balance and mobility, poor judgement,and difficulty communicating. Further, the CP identified R59 was resistive to cares with kicking or hitting, restless, and was unable to verbally express her wants or needs. Review of a facility incident report dated 5/9/15 at 5:30 p.m. revealed R59 had been found alone in her bathroom, lying on her right side on the floor. R59 had removed her top half of her clothes, and the clip alarm had not sounded. R59 was crying, her right eye swollen shut, and nose swollen and bleeding. R59 was protecting her right arm and shoulder and had a skin tear to right forearm and a bruise on her elbow. The report further indicated there were no witnesses to the incident, the resident room door had been shut, and R59's wheelchair had been found in her room. The report indicated R59 had been found on the floor after staff investigated the closed door, staff had been busy getting people to the dining room with no explanation of how there fall occurred. R59 had received follow up medical evaluation and had been diagnosed with a right clavicle fracture. The report identified various persons had been notified of the injury, however the report did not identify the administrator had been immediately notified of the injury of unknown origin. On 06/29/15, at 3:07 p.m. during interview, the director of nurses (DON) confirmed R59's injury of unknown origin on 5/9/15 had not been reported to the SA. On 06/30/15, at 1:34 p.m., during interview, social services (SS)-A stated, "All of us are responsible and required to report incidents of VA to the SA.	F 226	for both fall related situations as well as situations that may not be fall related (i.e. bruise or injury of unknown origin noted in a suspicious area like the groin or inner thighs, etc¿). Monitor: All incident reports will be reviewed at the daily IDT meeting and every incident report will be audited by the DON/ADON for appropriate VA reporting. Revise incident report to add "audited for VA" at the bottom by DON signature to check off after audit is completed. The audits will be reviewed at the quarterly QA meetings and department meetings. Audits will be done for every incident report and recorded for auditing for 6 months, but will continue to monitor thereafter. Completion Date: August 14, 2015	

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F 226	Continued From page 7 SS-A further stated the VA reporting is so broad, and a fall would be reported depending on the nurse and if their care plan was followed or it could have been prevented. SS-A stated it all depends on the circumstances if an incident would be reported or not. We go through the incident reports in the morning meetings. SS-A confirmed R59 had short term memory loss, disorganized thinking, lethargy, difficulty focusing, and had broken her clavicle after the unwitnessed fall. She confirmed the incident had not been reported to the SA. She further indicated she was not aware why the incident had not been reported and she felt the care plan must have been followed. She stated if they felt they could explain what happed to R59, so they had not reported the incident. On 06/30/15, at 2:22 p.m. during interview, the assistant director of nursing (ADON) and director of nursing (DON) confirmed the unwitnessed fall with injury for R59 on 5/9/15. The ADON stated she felt R59's care plan had been followed at the time of the incident and indicated the usual facility practice was to report if the resident had died after the fall. DON stated " Its the investigation we do that will determine if its reportable or not, if its not blatantly obvious." On 7/1/15, at 8:36 a.m., the facility administrator confirmed the current facility policy and confirmed R59 had a unwitnessed fall with injuries which included a fractured clavicle. She indicated she did not feel the injury of unknown origin for R59 was a reportable incident.	F 226		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		8/14/15

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F 314	Continued From page 8 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively re-assess a deteriorating pressure ulcer when the stage of the ulcer increased to a stage 3 for 1 of 2 residents (R58) reviewed for pressure ulcers. Findings include: R58's significant change in status Minimum Data Set (MDS) dated 6/8/15, identified R58 had diagnoses which included adult failure to thrive, congestive heart failure and anorexia. The MDS revealed R58 had severe cognitive impairment, needed physical assistance with activities of daily living (ADL's) and had a stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured blister.) R58's pressure ulcer Care Area Assessment (CAA) dated 6/22/15, identified R58 had an existing stage 2 pressure ulcer on the sacrum which was present upon admission. The CAA further revealed R58's pressure ulcer was noted to deteriorate to a stage 3 pressure ulcer (full	F 314	Resident R58: Comprehensive Assessment to include a Braden Scale/Risk assessment and Tissue Tolerance assessment was completed for the resident. Wound continues to be reassessed weekly and PRN. Other Residents: The other resident with a pressure ulcer was reassessed and no worsening in condition noted. No other residents affected. Systemic Changes: Tissue Tolerance and Identification of Residents at risk for skin breakdown policies were reviewed and updated. Education will be provided to all nurses at the August department meeting regarding the assessment process for worsening pressure ulcers. Monitor: Auditing form will be developed to audit all residents who currently have a pressure ulcer to include the dates of wound assessment, what stage the wound is at, and whether a tissue tolerance and	

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F 314	Continued From page 9 thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.) on 6/15/15, following the assessment reference date of 6/8/15 of the MDS. Review of R58's wound assessments reports from 4/17/15 to 6/30/15 revealed weekly wound documentation with the following changes noted: -6/8/15, the wound assessment revealed R58's sacral stage 2 pressure ulcer was unchanged from previous assessment, measured 0.4 centimeters (cm) by 0.4 cm by 0.1 cm. The assessment revealed the wound bed had 100% epithelial tissue (new skin that is light and shiny. In stage 2 pressure ulcers epithelial tissue is seen in the center and edges of the ulcer. In full thickness stage 3 and 4 pressure ulcers, epithelial tissue advances from the edges of the wound.) -6/15/15, the wound assessment revealed R58's sacral pressure ulcer had deteriorated from a stage 2 pressure ulcer to a stage 3 pressure ulcer. The assessment revealed the pressure ulcer measured 1.3 cm by 1.5 cm by 0.3 cm and the wound bed had 50% epithelial tissue and 50% granulation (red tissue with " cobblestone " or bumpy appearance, bleeds easily with injured.) The assessment further revealed a nursing note which identified R58's wound was a stage 3 pressure ulcer with full thickness skin loss extending down to the fascia (a thin sheath of fibrous tissue enclosing a muscle or other organ.) -6/18/15, the wound assessment revealed R58's stage 3 sacral pressure ulcer measured 0.8 cm	F 314	Braden scale was done. Auditing form will be initiated for any residents with new pressure ulcers as well. Auditing forms will be completed and monitored by the wound care nurses weekly for six months. The audits will be reviewed at the quarterly QA meetings. Completion Date: August 14, 2015	

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F 314	Continued From page 10 by 0.3 cm by 0.3 cm with 95% granulation tissue and 5% slough tissue (; non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.) -6/25/15, the wound assessment revealed R58's stage 3 sacral pressure ulcer was unchanged, measured 0.8 cm by 0.3 cm by 0.3 cm with 95% granulation tissue and 5% slough tissue. -6/30/15, the assessment revealed R58's stage 3 sacral pressure ulcer measured 1.0 cm by 0.5 cm by 0.3 cm with 95% granulation tissue and 5% slough tissue. The wound assessment identified the stage 3 pressure ulcer status had "deteriorated". A routine quarterly tissue tolerance testing (a test to determine the ability of ones skin and its supporting structures to endure the effects of pressure without adverse effects,) lying form dated 6/8/15, was completed during the reference period for R58's quarterly MDS. The test identified R58 had a pressure ulcer upon admission, was incontinent of bowel and bladder at times, had a potential problem with friction and shear, moved feebly and during a move R58's skin would probably slide on the sheets, chair (friction and shear.) The note further revealed R58's mobility was slightly limited, made frequent though slight changes in position independently and had been able to turn self in bed before 2 hours. However, a tissue tolerance test was not completed when R58's pressure ulcer worsened to a stage 3. A routine quarterly tissue tolerance testing sitting	F 314		

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F 314	Continued From page 11	F 314		

form dated 6/8/15, was completed during the reference period for R58's quarterly MDS. The test identified R58 was able to adjust self in chair, however would need occasional assistance to stand from a sitting position, had a potential problem with friction and shear with self transfers and moved feebly with skin sliding to some extent against chair. However, a tissue tolerance test was not completed when R58's pressure ulcer worsened to a stage 3.

A routine quarterly Braden risk assessment report dated 6/8/15, was completed during the reference period for R58's quarterly MDS. The assessment identified R58 was at mild risk for pressure ulcer development/skin breakdown. However, a Braden risk assessment was not completed when R58's pressure ulcer worsened to a stage 3.

The facility lacked documentation a comprehensive assessment was completed following identification of the deterioration of R58's pressure ulcer from a stage 2 to a stage 3 on 6/15/15.

Review of departmental notes from 4/17/15 to 6/30/15, revealed the following regarding the deterioration of R58's pressure ulcer.
-6/8/15, the note revealed R58 had a stage 2 pressure ulcer with the treatment of a Aquacel AG (dressing impregnated with silver) tegaderm foam to coccyx, check every shift and change PRN (as needed.) The note further revealed interventions in place were a ROHO cushion (inflatable cushion used for pressure relief) in chair and an alternating pressure mattress on the bed.
-6/15/15, the note revealed R58 had a stage 2 pressure ulcer, treated with an Aquacel AG/tegaderm foam dressing, check every shift

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	245485	A. BUILDING _____ B. WING _____	07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON MEMORIAL HOSP & HOME	1282 WALNUT STREET DAWSON, MN 56232

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and change PRN. The note further revealed interventions that were in place was a ROHO cushion and an alternating pressure mattress. An addendum was noted which revealed R58's pressure ulcer was a stage 3, measured 1.3 by 0.5 by 0.3 cm. The treatment in place was an Aquacel AG/tegaderm foam.

R58's care plan dated 6/15/15, identified R58's pressure ulcer was a stage 3 as of 6/15/15, had an alternating pressure mattress and a ROHO cushion in chair. The care plan directed facility nursing staff to complete a Tissue Tolerance and Braden Scale per policy, and to monitor R58's skin condition every shift with cares.

Review of R58's undated July 2015, physician orders lacked any order treatment of R58's pressure ulcer.

Review of R58's June Treatment Administration Record (TAR) revealed an undated nursing order of a Aquacel AG/Op-Site to sore on coccyx, check every shift and change dressing PRN, discontinued 6/30/15. Another undated nursing order directed nursing staff to cleanse wound with saline wound wash, wipe area with no sting skin barrier, apply Aquacel AG to wound and secure with Op-Site, cover with tegaderm foam for padding, check dressing every shift and change PRN.

Review of R58's July TAR revealed an undated nursing order to cleanse R58's wound with saline wound wash, wipe area with no sting skin barrier, apply Aquacel AG to wound and secure with Opsite, cover with tegaderm foam for padding, check dressing every shift and change PRN.

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A physician care center note dated 6/19/15, identified R58 had a sacral pressure ulcer, the physician was shown a photograph of R58's pressure ulcer. The note further identified R58's pressure ulcer was a stage 3 with the nursing order to cleanse the area and apply Aquacel silver, an Op-site. The notes assessment identified R58's pressure ulcer was followed by the facility wound nurse.

On 6/30/15, at 1:39 p.m. an observation of R58's dressing change was conducted with Registered Nurse (RN)-A present. Observation of R58's sacral area revealed a stage 3 pressure ulcer on R58's sacrum, which measured 1.0 cm by 0.5 cm by 0.3 cm and the wound bed was not fully visible due to the presence of slough tissue. The tissue presence of the wound bed consisted of 95% granulation and 5% slough tissue.

On 6/30/15, at 1:53 p.m. RN-A confirmed R58's pressure ulcer had deteriorated from a stage 2 to a stage 3 and the wound bed was not fully visible. RN-A confirmed a comprehensive assessment was not completed following the worsening of R58's pressure ulcer. RN-A further revealed a comprehensive assessment would include completion of a tissue tolerance test and a Braden scale.

On 7/1/15, at 8:19 a.m. the director of nursing (DON) stated the facility had two certified wound nurses who managed residents wounds, including R58's pressure ulcer. The DON stated she would expect a comprehensive assessment to be completed when a pressure ulcer deteriorated. The DON confirmed R58 should have been re-assessed when the pressure ulcer worsened to a stage 3 and had not been

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F 314	Continued From page 14 re-assessed. Review of a facility policy and procedure titled, pressure ulcer assessment and treatment revised 10/14, directed facility to re-assess every week and more often as needed., alter treatment plan if no evidence of healing in 2-4 weeks. Review of a facility policy and procedure titled, Identification of Residents at Risk for Skin Breakdown revised 10/14, revealed a policy to properly identify and assess residents whose clinical condition increased the risk for impaired skin integrity, and pressure ulcers. The policy directed facility staff to complete a Braden scale assessment with a significant change in skin condition. The policy further directed facility staff to utilize the Resident Assessment Instrument (RAI) process to identify potential risk factors. Review of a facility policy and procedure titled, Tissue Tolerance revised 10/14, directed facility staff to complete a tissue tolerance with a significant change of condition and upon worsening of skin condition and when an area healed.	F 314		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		8/1/15

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F 431	Continued From page 15 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure expired stock medical supplies where not available for use by residents in 2 of 3 medication/treatment carts. Findings include: On 6/28/15 at 2:00 p.m. during observation of the facility medication cart number one, with registered nurse (RN)-D present, a opened, half full bottle of Geri Care colace (stool softener),	F 431	Resident: No resident was affected. Other Residents: No residents were affected. Systemic Changes: The nurses will all be assigned a group of residents to check their medication cabinets for expired medications and products by the 15th of every month. The medication room (stock meds), medication carts and treatment cart will be	

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F 431	Continued From page 16 with a expiration date of 1/15 was noted. RN-D confirmed the finding, immediately removed the expired medication and indicated she would discard the medication,. On 6/28/15 at 2:15 p.m. during observation of the facility treatment cart with RN-A present, one tube of Santyl wound cream(prescription enzymatic debriding ointment) with an expiration date of 10/14, one bottle of Nystop(antifungal medication) powder with an expiration date of 11/14, five packages of tegaderm dressings with an expiration date of 9/12 and 2 packages of Exsalt wound dressings(antimicrobial silver dressing) with an expiration date of 10/14. RN-A confirmed the findings and stated "no they should not be in the cart, they are expired." During an interview on 6/28/15, at 2:20 p.m. trained medical assistant (TMA)-A stated TMA-B was responsible for ordering stock medications and supplies for the facility. TMA-A also stated TMA-B was responsible for checking the medication room, medication carts and treatment carts for outdated supplies. During interview on 6/28/15 at 2:35 p.m. RN-A confirmed the expired medical supplies on the medication/treatment cart and confirmed the medication/supplies were available to be used for any resident in the facility. RN-A verified the expired supplies should not be in the carts, and immediately discarded the supplies. During interview on 7/1/15 at 1:40 p.m. director of nursing (DON) confirmed the expired medical supplies in the medication/treatment carts and stated, "I would expect them (staff) to remove the expired products and supplies and not use them."	F 431	checked for expired medications and products on the first Sunday of every month by the night nurse. Education provided to the nurses at the August staff meeting. Policies #6.10 and #3.6 were revised to reflect changes. Monitor: The DON/ADON will complete an audit on both medication carts, the treatment cart and 10 random resident medication cabinets monthly for six months. The audits will be reviewed at the quarterly QA meetings and department meetings. Completion Date: August 1, 2015	

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F 431	Continued From page 17 The DON also verified staff should be putting the expired stock supplies in the cupboard to be destroyed and stated, "Yes there is potential for staff to use these products and these should not be in the carts." Review of facility policy titled, Removal, Storage and Destruction of Discontinued Drugs, revised on 1/14, directed all medications except controlled, no longer in use due to resident discharge, or death, or expired medications, will immediately be disposed of by putting in coffee grounds or flushing in the sewer system. Under Destruction Procedure the policy directed all non-controlled substances and/or supplies shall be destroyed by an RN and witnessed by another licensed nurse after one month. No further policies regarding expired medications and supplies were provided.	F 431		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF FORM CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on June 30, 2015. At the time of this survey, Johnson Memorial Hospital and Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/23/2015

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

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K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Johnson Memorial Hospital and Home is a one-story building with partial basement. The original building was constructed in 1959, with building additions constructed in 1962, 1982 and 1993. All buildings were determined to be of Type II(111) construction. The building is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 56 beds and had a census of 52 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated	K 027		7/28/15

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K 027	Continued From page 2 protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Observations and testing of the five sets of smoke barrier doors revealed that three do not meet the requirements of NFPA 101 "The Life Safety Code" (2000 edition) section 19.3.7.6. This deficient practice could negatively affect all the residents, visitors and staff in a fire emergency by allowing the products of combustion to travel from one smoke compartment to another. Findings include: During the facility tour on June 30, 2015, between 08:00 am and 12:00 PM, revealed that the smoke barrier doors did not work as designed, keeping the smoke barrier door leaves from fully closing. This included the South Hall set of smoke barrier doors. This finding was verified by the Enviromental Services Manager (SO) during the facility tour.	K 027	We will adjust the door closers on the smoke doors so they close at the proper speed. We will also adjust the doors so they close fully without rubbing.	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in	K 056		7/30/15

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K 056	Continued From page 3 accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide proper coverage of the fire sprinkler system as per 2000 NFPA 101 Chapter 19.3.5 and 9.7. The deficient practice could affect 15 out of 52 residents. FINDINGS INCLUDE: On facility tour between 8:00 AM and 12:00 PM on 06/30/2015, observation revealed that the main entrance vestibule does not have a fire sprinkler protection. This deficient practice was confirmed by the Enviromental Service Manager (SO) at the time of discovery.	K 056	We will have Viking Sprinkler install a sprinkler head in the main entrance. This will be done as soon as their schedule allows. (unsure of completion date due to Viking Sprinkler not giving a date as to when they can be here).	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		7/6/15

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K 144	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to properly inspect the emergency generator in accordance with NFPA 99 (1999 edition) and NFPA 110 (1999 edition). This deficient practice could effect all residents. Findings include: Between 8:00 AM and 12:00 PM 06/30/2015, based upon a staff interview and review of available records, the facility did not perform weekly inspections form 09/19/2014 - 10/02/2014 for the emergency generator. This deficient practice was verified by the Enviromental Services Manager (SO).	K 144	We will be sure that weekly inspections are done every week.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, electrical installations are not in accordance with NFPA 70 "The National Electrical Code 1999 edition. section 9.1.2. This deficiency could negatively effect the 20 of 52 residents. Findings include:	K 147	We have done room and office checks to make sure extension cords are not in use. We will also make sure power strips are not in use. Will continue to check to make sure no extension cords are in use.	7/16/15

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K 147	Continued From page 5 On facility tour between 8:00 AM and 12:00 PM on 06/30/2015, it was observed: 1. Room 12 had a lamp plugged into an extension cord. 2. The organ in the chapel was plugged in with an extension cord. 3. Office Rm #4 had a refrigerator plugged into a power strip. This deficient practice was verified by Enviromental Services Manager (SO).	K 147		