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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL** — ID: SJC5

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY** — Facility ID: 00717

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245511**

2.STATE VENDOR OR MEDICAID NO.
(L2) **865402000**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRACARE HEALTH - MONTICELLO**
(L4) **1013 HART BOULEVARD**
(L5) **MONTICELLO, MN** (L6) **55362**

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) **04/01/2013**

6. DATE OF SURVEY **01/23/2014** (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 **89** (L18)

13.Total Certified Beds **89** (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:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 89 | | | |
| (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 :
Brenda Fischer, Unit Supervisor — 01/23/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 03/13/2014 (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
**01/01/1988**
(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.
**00320**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
**01/29/2014**
(L33)

DETERMINATION APPROVAL

Page 2
Provider Number: 24-5511
Item 16 Continuation for CMS-1539

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective February 7, 2013, the facility is certified for 89 skilled nursing facility beds.

## Larson, Monica (MDH)

**From:** Larson, Monica (MDH)
**Sent:** Wednesday, March 12, 2014 12:01 PM
**To:** *MDH_surveys
**Cc:** Larson, Monica (MDH) (monica.larson@state.mn.us)
**Subject:** Centracare Health Monticello 1539 is incorrect
**Attachments:** 1539 .pdf

Afternoon,
Please up date 1539 to reflex a PCR. Also is now a A.

Thank you,
Monica

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

Medicare Provider # 245511

February 23, 2014

Ms. Mary Ellen Wells, Administrator
Centracare Health - Monticello
1013 Hart Boulevard
Monticello, Minnesota 55362

Dear Ms. Wells:

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 January 14, 2014 the above facility is certified for:

89 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 89 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.

Sincerely,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

January 23, 2014

Ms. Mary Ellen Wells, Administrator
Centracare Health - Monticello
1013 Hart Boulevard
Monticello, MN 55362

RE: Project Number S5511023

Dear Ms. Wells:

On December 17, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 5, 2013. 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 January 23, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 10, 2014 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 December 5, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 14, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 5, 2013, effective January 14, 2014 and therefore remedies outlined in our letter to you dated December 17, 2013, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Brenda Fischer

Brenda Fischer, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 320-223-7338 Fax: 320-223-7348

Enclosure

cc: Licensing and Certification File

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 |
|---|---|---|
| 245511 | A. Building<br>B. Wing | 1/23/2014 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| CENTRACARE HEALTH - MONTICELLO | 1013 HART BOULEVARD<br>MONTICELLO, MN 55362 |

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 Correction Completed | (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed |
|---|---|---|---|---|---|
| ID Prefix F0322<br>Reg. # 483.25(g)(2)<br>LSC | 01/14/2014 | ID Prefix F0323<br>Reg. # 483.25(h)<br>LSC | 01/14/2014 | ID Prefix F0329<br>Reg. # 483.25(l)<br>LSC | 01/14/2014 |
| ID Prefix F0428<br>Reg. # 483.60(c)<br>LSC | 01/14/2014 | ID Prefix F0441<br>Reg. # 483.65<br>LSC | 01/14/2014 | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |

| Reviewed By State Agency | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| V | 10562 | 1/23/14 | | |
| **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? | |
|---|---|---|
| 12/5/2013 | | YES NO |

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 |
|---|---|---|
| 245511 | A. Building<br>B. Wing 01 - MAIN BUILDING 01 | 1/10/2014 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| CENTRACARE HEALTH - MONTICELLO | 1013 HART BOULEVARD<br>MONTICELLO, MN 55362 |

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 12/13/2013 | ID Prefix | Correction Completed 12/05/2013 | ID Prefix | Correction Completed 12/19/2013 |
| Reg. # NFPA 101<br>LSC K0011 | | Reg. # NFPA 101<br>LSC K0022 | | Reg. # NFPA 101<br>LSC K0029 | |
| ID Prefix | Correction Completed 12/05/2013 | ID Prefix | Correction Completed | ID Prefix | Correction Completed |
| Reg. # NFPA 101<br>LSC K0038 | | Reg. #<br>LSC | | Reg. #<br>LSC | |
| ID Prefix | Correction Completed | ID Prefix | Correction Completed | ID Prefix | Correction Completed |
| Reg. #<br>LSC | | Reg. #<br>LSC | | Reg. #<br>LSC | |
| ID Prefix | Correction Completed | ID Prefix | Correction Completed | ID Prefix | Correction Completed |
| Reg. #<br>LSC | | Reg. #<br>LSC | | Reg. #<br>LSC | |
| ID Prefix | Correction Completed | ID Prefix | Correction Completed | ID Prefix | Correction Completed |
| Reg. #<br>LSC | | Reg. #<br>LSC | | Reg. #<br>LSC | |

| | | | | |
|---|---|---|---|---|
| Reviewed By ✓<br>State Agency | Reviewed By<br>10562 | Date:<br>1/23/14 | Signature of Surveyor: | Date: |
| Reviewed By<br>CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

| | |
|---|---|
| Followup to Survey Completed on:<br>12/4/2013 | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO |

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 |
|---|---|---|
| 245511 | A. Building 01 - MAIN BUILDING 01<br>B. Wing | 1/10/2014 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| CENTRACARE HEALTH - MONTICELLO | 1013 HART BOULEVARD<br>MONTICELLO, MN 55362 |

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).

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| ID Prefix | Correction Completed 12/13/2013 | ID Prefix | Correction Completed 12/05/2013 | ID Prefix | Correction Completed 12/19/2013 |
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| ID Prefix | Correction Completed 12/05/2013 | ID Prefix | Correction Completed | ID Prefix | Correction Completed |
| Reg. # NFPA 101<br>LSC K0038 | | Reg. #<br>LSC | | Reg. #<br>LSC | |
| ID Prefix | Correction Completed | ID Prefix | Correction Completed | ID Prefix | Correction Completed |
| Reg. #<br>LSC | | Reg. #<br>LSC | | Reg. #<br>LSC | |
| ID Prefix | Correction Completed | ID Prefix | Correction Completed | ID Prefix | Correction Completed |
| Reg. #<br>LSC | | Reg. #<br>LSC | | Reg. #<br>LSC | |
| ID Prefix | Correction Completed | ID Prefix | Correction Completed | ID Prefix | Correction Completed |
| Reg. #<br>LSC | | Reg. #<br>LSC | | Reg. #<br>LSC | |

| | | | | |
|---|---|---|---|---|
| Reviewed By ✓<br>State Agency | Reviewed By<br>10562 | Date:<br>1/23/14 | Signature of Surveyor: | Date: |
| Reviewed By<br>CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

| | |
|---|---|
| Followup to Survey Completed on:<br>12/4/2013 | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO |

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL** — ID: SJC5

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY** — Facility ID: 00717

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245511**

2.STATE VENDOR OR MEDICAID NO.
(L2) **865402000**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRACARE HEALTH - MONTICELLO**
(L4) **1013 HART BOULEVARD MONTICELLO, MN**
(L5) (L6) **55362**

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) **04/01/2013**

6. DATE OF SURVEY **12/05/2013** (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 **89** (L18)

13.Total Certified Beds **89** (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 |
|---|---|---|---|---|
| | 89 | | | |
| (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 :
Karen Aldinger, HFE NE II — 01/15/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 01/27/2014 (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
**01/01/1988**
(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.
**00320**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN-245511

At the time of the standard survey completed December 5, 2013, the facility was not in substantial compliance and the most serious deficiencies were found 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.The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

Certified Mail # 7012 3050 0001 9094 7086

December 17, 2013

Ms. Mary Ellen Wells, Administrator
Centracare Health–Monticello
1013 Hart Boulevard
Monticello, Minnesota 55362

RE: Project Number S5511023

Dear Ms. Wells:

On December 5, 2013, 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:

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

**<u>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:

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320) 223-7338
Fax: (320) 223-7348

**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 January 14, 2014, 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 January 14, 2014 the following remedy will be imposed:

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

**PLAN OF CORRECTION (PoC)**

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC 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 PoC 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 PoC for the respective deficiencies (if any) is acceptable.

**VERIFICATION OF SUBSTANTIAL COMPLIANCE**

Upon receipt of an acceptable PoC, 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner

than the latest correction date on the PoC.

**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 March 5, 2014 (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 June 5, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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 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
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

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 |
|---|---|---|---|
| | 245511 | A. BUILDING _____ B. WING _____ | 12/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CENTRACARE HEALTH - MONTICELLO | 1013 HART BOULEVARD MONTICELLO, MN 55362 |

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| F 000 | INITIAL COMMENTS<br><br>The facility's plan of correction (POC) 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.<br><br>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. | F 000 | | |
| F 322 SS=D | 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that --<br><br>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and<br><br>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.<br><br>This REQUIREMENT is not met as evidenced | F 322 | **F322-GTUBE MEDICATION ADMINISTRATION**<br><br>The nurse Administering Medications for Resident 12 was immediately re-educated about the Procedure for G Tube Medication Administration.<br><br>The Policy/Procedure for Medication Administration through a GTube has been reviewed and updated.<br><br>Licensed staff responsible for Medication Administration have been re-educated on the Policy/Procedure for Medication Administration through a GTube.<br><br>Licensed staff will successfully complete a return demonstration of Medication Administration through a G Tube.<br><br>1/15/14 ok accepted | 01/14/2014 |

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

Teri Vicklund | Division Director Clinical - Care Center | 1/14/14

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| F 322 | Continued From page 1<br>by:<br>Based on observation, interview and document review, the facility failed to properly administer medications through gastrostomy (g-tube) feeding tube for 1 of 1 residents (R12) reviewed for medication administration via g-tube.<br><br>Findings include:<br><br>R12's Resident Diagnosis Listing dated 12/4/13, indicated R12's diagnoses included a gastrostomy tube (a tube inserted through the abdominal wall into the stomach) and dsyphagia (difficulty swallowing).<br><br>The medication administration care plan dated 9/4/13, indicated R12 was unable to administer medication due to a traumatic brain injury and all medications would be administered by the nursing staff. The sensory/communication/orientation care plan dated 9/4/13, indicated R12 was comatose and unable to communicate any needs.<br><br>During observation on 12/4/13, at 7:15 a.m. licensed practical nurse (LPN)-A was observed setting up R12's medications to be administered through the g-tube. LPN-A crushed a multivitamin and set it aside in a small amount of water, a package of Mirilax was added to the multivitamin mixture along with a calcium supplement and two anticonvulsant medications. All the medications were mixed together and allowed to sit until 8:30 a.m. LPN-A then checked placement of the g-tube, administered 60 ml (milliliter) of water, drew up the medications that had been mixed together and administered them to R12. She then flushed the g-tube with water. | F 322 | New Licensed staff will be required to successfully complete a return demonstration administering medications through a G Tube during their clinical orientation.<br><br>Medication Administration audits will be done weekly x 1 month, then 2x monthly for 2 months, and then quarterly x 1.<br><br>Audit results will be brought to the Quality Assurance Committee for review.<br><br>The Director of Nursing/designee is responsible for maintaining compliance. | |

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| F 322 | Continued From page 2<br>When interviewed on 12/4/13, at 11:05 a.m. LPN-A stated she always mixes R12's medications together and had never been instructed to give each medication separately, flushing with water between them.<br><br>R12's physician orders dated 10/14/13, directed staff to crush the multivitamin and let it sit in lukewarm/cool water for at least 15 minutes prior to administration. The physician orders did not indicate it was acceptable to mix all medication together.<br><br>When interviewed on 12/4/13, at 1:15 p.m. the director of nursing (DON) stated R12's medications were to be given separately and the facility's policy directed staff to give each medication separately and flush with water between each medication.<br><br>The facility's Feeding Tube Instilling Medications policy dated 9/04, indicated the purpose of the policy was to ensure medications were administered appropriately and safely when a resident had a feeding tube in place. The policy directed staff to give each medication separately and flush with water between each medication. | F 322 | | |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. | F 323 | **F323**<br>**ACCIDENTS/SUPERVISION/DEVICES**<br><br>Resident 79 immediately had his bed replaced with a bed that has no side rails. | 01/14/2014 |

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| F 323 | Continued From page 3<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure bed side rails fit the bed properly, and were evaluated to ensure openings within the rails were of proper size, to reduce entrapment risk for 1 of 4 residents (R79) reviewed who had cognitive impairment and utilized bed side rails.<br><br>Findings include:<br><br>R79's quarterly Minimum Data Set (MDS) dated 9/24/13, indicated he had a diagnosis of dementia, had moderate cognitive impairment, required extensive assistance with bed mobility, and had unsteady balance with transfers.<br><br>R79's care plan dated 9/24/13, included he was at risk for falls and injury due to a history of falls, unsteady gait, incontinence, and cardiac drug use. The plan instructed staff to utilize alarm systems and 1/2 side rails on bed.<br><br>When interviewed on 12/2/13, at 2:00 p.m. licensed practical nurse (LPN)-C stated R79 utilized upper 1/2 side rails on both sides of bed and was unsafe to transfer himself out of bed. The alarm systems was utilized to alert staff, as he will make attempts to self transfer.<br><br>During observation on 12/2/13, at 2:35 p.m. R79 had bilateral side rails at the head of the bed. The rails had 3 large gaps within the rails themselves (zone 1). The gaps measured 7.75 " (inches) by 7.5", 8.5" by 7.75", and 7.75" x 7.5". Also the mattress was slid over to the right side rail exposing the bed frame on the left side. The | F 323 | All facility beds having side rails have been audited to determine if the side rails meet the FDA requirements identified in the Hospital Bed System Dimensional and Assessment Guide to Reduce Entrapment.<br><br>All beds with lower ½ side rails have either had the rail removed, or zip-tied down to prevent use.<br><br>All beds with side rails that have been determined to be an unsafe fit for the bed will be removed.<br><br>Residents will be assessed to demonstrate safe use of the side rails/grab bars and will be re-assessed on a quarterly basis for safety.<br><br>Results of the side rail audit/interventions will be reviewed by the Quality Assurance Committee. | |

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| F 323 | Continued From page 4<br>rail to the bed frame (zone 2) measured 5.5". Under the edge of the rail to the bed frame (zone 4) measured 5.75".<br><br>When interviewed on 12/4/13, at 9:15 a.m. nursing assistant (NA)-A stated R79 makes attempts to transfer himself out of his bed at times, his balance is poor and he should not do this, but wants to be independent.<br><br>Review of R79's record indicated a Informed Choice Consent for Physical Devices, dated 12/19/12, indicated 1/2 side rails were being used for "mobility and safety." This form did not include an evaluation if R79 was safe to use these rails with the large gaps in them.<br><br>R79's Safety Risk Assessment dated 2/15/13, included the use of 1/2 side rails on bed, fall mat sensor, and personal alarm. The form indicated R79 was at risk for falls related to dementia, impaired judgement, and an unsteady gait. There was no indication, the facility had assessed R79, was safe to use the side rails with the large gaps.<br><br>R79's side rails were observed with the environmental service director (ESD) on 12/4/13, at 1:00 p.m. the ESD verified the above measurements. The ESD stated she was not aware the FDA had guidelines for bed side rails to reduce entrapment risk. The facilities rails had never been evaluated against these guidelines.<br><br>When interviewed on 12/5/13, at 9:45 a.m. registered nurse (RN)-B, stated R79 uses the bed side rails for repositioning in bed. The facility had not evaluated the large gaps in R79's bed side rails to determine if they were safe for him to use. | F 323 | | |

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| F 323 | Continued From page 5<br>A facility policy entitled, Restraint Use/Safety Devices, dated 11/09, included, "Devices will be implemented to maintain a safe environment prior to restraint use. Safety devices are monitored for general effectiveness." The policy did not include any individualized resident assessment to determine if particular side rails are safe for use.<br><br>The Federal Drug Administration (FDA) guidance for Bed System Dimensional and Assessment Guidance to Reduce Entrapment issued 3/10/06, included recommendations intended to reduce life-threatening entrapments associated with bed side rails. The guidance defined patients at risk for entrapment as those who are elderly, have problems with memory, urinary incontinence, or walk unsafely without assistance. The recommendations are for less than 4.75" (a space where a head could get caught) in zone 1, less than 4.75" for zone 2, and less than 2 3/8" (a space where a neck could get caught) in zone 4.<br><br>R79's bed rails had larger than the recommended gaps in each of these zones, creating a potential entrapment hazard for R79. | F 323 | | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. | F 329 | **F329 UNNEECESSARY DRUGS**<br><br>Resident 89- The Seroquel 25 mg 1 tab po PRN at bedtime was discontinued on 12/6/13. Social Services did discuss a room change with Resident 89 on 12/6/13, and he declined the opportunity to change rooms. | 12/06/2013 |

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| F 329 | Continued From page 6<br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure adequate justification and non-pharmacological interventions were attempted prior to the use of an antipsychotic medication, for 1 of 3 residents (R89) reviewed who was prescribed an antipsychotic medication.<br><br>Findings include:<br><br>R89's admission Minimum Data Set (MDS) dated 9/27/13, included a diagnosis of Alzheimer's disease, and severe cognitive impairment. There was no indication of a psychotic disorder, any behavior problems or indicators of delirium for R89.<br><br>R89's care plan dated 9/8/13, included intermittent confusion but did not identify any delirium, behavior problems, or psychosis of any sort. | F 329 | Room relocation options will continue to be offered to the resident as they become available. A sleep study was completed and showed periods of awakening throughout the night, sometimes due to resident requests to use the bathroom. Non-pharmacological interventions are being trialed with the resident as he allows. Care Plan updated.<br><br>Beginning January 1, 2014, residents who have prescribed antipsychotic medication will have their medications reviewed by Pharmacy for indication of use during their next scheduled assessment period. and quarterly thereafter.<br><br>Results will be brought to the Quality Assurance Committee for review.<br><br>Social Services will be responsible for maintaining compliance on non-pharmacological interventions.<br><br>The Director of Nursing/designee is responsible for overall compliance. | 01/14/2014 |

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| F 329 | Continued From page 7 | F 329 | | |

R89 was interviewed on 12/2/13, at 7:05 p.m. and stated he has some trouble sleeping at night because his room mate talks and mumbles all night. This disrupts his sleep and causes him to feel tired during the day. R89 stated he thought the facility was trying to find him a new room mate so he can have a quiet and restful night.

During interview on 12/2/13, at 7:30 p.m. licensed practical nurse (LPN)-D stated R89 does not have any behavior problems or psychotic episodes. He does try to self transfer at times and shouldn't, because he was unsteady.

When interviewed on 12/5/13, at 9:20 a.m. nursing assistant (NA)-B stated R89 has never shown any behavior problems or psychosis. He is pleasant and cooperative, but he likes to be independent and will transfer himself and needs reminders that it is not safe.

Review of R89's record identified Physician Orders, dated 9/5/1/3, included, "Seroquel [an antipsychotic medication] 25 mg [milligrams] p.o. [orally] hs [at bedtime] prn [as needed] unable to sleep."

R89's Pharmacist Drug Regimen Reviews, dated 9/27/13, included the pharmacists recommendations of, "Seroquel 25 mg q [every] hs prn unable to sleep-Sleep is not an indication for use of Seroquel. Recommend sleep study-non pharm [pharmacological] interventions." The primary physician wrote a note under this dated 9/30/13, "Have we used Seroquel for outbursts? He has hx [history] of irritable and outburst when not sleeping at home. He is basically hospice and sleep study for

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| F 329 | Continued From page 8<br>dementia related problems not indicated." There were no nursing notes or follow up addressing the question from the physician.<br><br>R89's Patient Information physician progress note dated 10/20/13, included, "He does have sundown syndrome and tends to hallucinate and call out more at night. Does frequently get the Seroquel between 11 and 2:30 when he is unable to sleep and the 25 mg of Seroquel has been helpful."<br><br>R89's September 2013 Medication Administration Record (MAR) indicated R89 had been administered the Seroquel on 9/21/13, 9/27/13, and 9/28/13. Each time the reason was listed as "unable to sleep." On 9/28/13 the results of giving the Seroquel was noted to be, "Resting." The other two times staff failed to identify if giving the Seroquel was helpful or not. R89's September 2013 Mood and Behavior Flow Sheets failed to identify any signs of delusions, sundowning, hallucinations, or behavior problems. R89's September Interdisciplinary Record and Progress Notes showed R89 slept a lot during the day, attempted to self transfer frequently, but had no hallucinations, delusions, or behavior problems. There were no problems identified when R89 had been administered Seroquel for "unable to sleep."<br><br>R89's October 2013 MAR indicated R89 had been administered the Seroquel 14 times. Each time the reason was listed as, "Insomnia," or "Sleep." R89's October 2013 Mood and Behavior Flow Sheet's failed to identify any signs of delusions, hallucinations, sundowning, or behavioral problems. R89's October 2013 Interdisciplinary Record and Progress Notes | F 329 | | |

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| F 329 | Continued From page 9 | F 329 | | |

showed R89 stayed in bed "too often," and continued self transfers. On 10/12/13 the notes included,"Res [resident] noted to be upset about room mate talking in sleep." He wanted to tell the room mate to, "Just shut-up," and was redirected. He was then assisted to stay in a different room for the night. On 10/20/13 he had refused a bath, the note indicated he was given Seroquel because of this.

R89's November 2013, MAR indicated R89 had been administered the Seroquel three times, once for "insomnia," the other times had no reason given at all. The November 2013 Mood and Behavior Flow Sheet identified only one behavior on 11/12/13, as being upset with room mate and telling him to "shut up." The November 2013 Interdisciplinary Record and Progress Notes included attempts to self transfer, and on 11/10/13, R89 was yelling at his room mate to be quiet and go to sleep. On 11/11/12, again R89 was upset with room mate being too noisy. On 11/11/13, R89 was offered ear plugs to help with the noise level from his room mate at night. On 11/13/13, R89 complained to staff about his room mate being too loud, would not wear the ear plugs, so the Seroquel was given. On 11/24/13, the notes included, "Resident yelling at room mate to be quiet during the night. Room mate dreaming and mumbling sometimes talking, waking resident up. This nurse gave both residents their scheduled meds to see if would settle them both. Did not help that much."

When interviewed on 12/5/13, at 9:15 a.m. the facilities consultant pharmacist stated Seroquel should not be given for insomnia, R89's Seroquel was being given for sundowning and calling out. The pharmacist was not aware R89 continued to

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|---|---|---|---|
| | 245511 | A. BUILDING _____ B. WING _____ | 12/05/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CENTRACARE HEALTH - MONTICELLO | 1013 HART BOULEVARD MONTICELLO, MN 55362 |

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| F 329 | Continued From page 10<br>receive the Seroquel for insomnia/sleep problems, nor was she aware R89's room mate was noisy keeping R89 awake at night. The pharmacist stated the facility should address the underlying cause of the insomnia and attempt non-pharmacological interventions instead of using Seroquel for sleep.<br><br>When interviewed on 12/5/13, at 9:50 a.m. registered nurse (RN)-B stated she was aware R89's room mate was noisy and causing sleep problems for him. They had provided him with ear plugs, but she did not know if R89 used them or not. She was not aware of any attempts to obtain a different room mate for R89 and stated the MDS nurse was responsible for placing non-pharmacological interventions on the care plan to aide with sleep.<br><br>When interviewed on 12/5/13, at 10:20 a.m. the MDS nurse RN-C stated she was not aware of R89's problems sleeping due to room mate talking at night, and was not aware R89 was getting medicated with Seroquel due to trouble sleeping.<br><br>When interviewed on 12/5/13, at 10:40 a.m. Social worker (SW)-A stated she was aware R89 had been having trouble sleeping due to room mate being noisy and had been provided with ear plugs. She was not aware of any other interventions being used to assist R89 to sleep at night, nor had any attempts made to get R89 a different room mate. Currently there were no rooms available at the facility. | F 329 | | |
| F 428 SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON | F 428 | **F428 DRUG REGIMIN REVIEW**<br><br>Per Pharmacy Recommendation dated 9/27/13, Resident 89 had a sleep study completed and non-pharmacological interventions trialed as the resident would allow. | 01/14/2014 |

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| F 428 | Continued From page 11<br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to follow pharmacy consultant recommendations for 1 of 3 residents (R89) who received an antipsychotic medication.<br><br>Findings include:<br><br>R89's admission Minimum Data Set (MDS) dated 9/27/13, included a diagnosis of Alzheimer's disease, severe cognitive impairment, did not have a psychotic disorder, any behavior problems or indicators of delirium.<br><br>R89 was interviewed on 12/2/13, at 7:05 p.m. and stated he has some trouble sleeping at night because his room mate talks and mumbles all night. This disrupts his sleep and causes him to feel tired during the day.<br><br>R89's Physician Orders, dated 9/5/1/3, included, "Seroquel [an antipsychotic medication] 25 mg [milligrams] p.o. [orally] hs [at bedtime] prn [as needed] unable to sleep."<br><br>R89's Patient Information physician progress note | F 428 | Beginning January 2014, the DON will review the Pharmacy Recommendations and forward to RN Nurse Manager for physician/nurse communication and response to the action requested. The RN Nurse Manager will track responses and report monthly to the Quality Assurance Workgroup x 3 months.<br><br>Results of action response will be reviewed by the Quality Assurance Committee.<br><br>The LTC RN Nurse Manager/designee is responsible for compliance. | |

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| F 428 | Continued From page 12<br>dated 10/20/13, included, "He does have sundown syndrome and tends to hallucinate and call out more at night. Does frequently get the Seroquel between 11 and 2:30 when he is unable to sleep and the 25 mg of Seroquel has been helpful."<br><br>Review of R89's September through November 2013 Medication Administration Record (MAR) indicated R89 had been administered the Seroquel 20 times from 9/21/13 through 11/30/13, for being "unable to sleep, insomnia" or rational was left blank.<br><br>R89's Mood and Behavior Flow sheets and Interdisciplinary Record and Progress Notes dated 9/1/13 through 12/5/13, did not identify any sundown syndrome or hallucinations. The notes did include R89 had trouble sleeping because his room mate talked and mumbled at night. R89 had been offered ear plugs on 11/11/13, but no other non-pharmacological interventions had been mentioned to aide R89 with sleeping.<br><br>R89's Pharmacist Drug Regimen Reviews, dated 9/27/13, included the pharmacists recommendations of, "Seroquel 25 mg q [every] hs prn unable to sleep-Sleep is not an indication for use of Seroquel. Recommend sleep study-non pharm [pharmacological] interventions." The primary physician wrote a note under this dated 9/30/13, "Have we used Seroquel for outbursts? He has hx [history] of irritable and outburst when not sleeping at home. He is basically hospice and sleep study for dementia related problems not indicated." There were no nursing notes or follow up addressing the question from the physician. | F 428 | | |

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| F 428 | Continued From page 13<br>When interviewed on 12/5/13, at 9:15 a.m. the consultant pharmacist stated Seroquel should not be given for insomnia, R89's Seroquel was being given for sundowning and calling out. The pharmacist was not aware R89 continued to receive the Seroquel for insomnia/sleep problems, nor was she aware R89's room mate was noisy keeping R89 awake at night. She stated the facility should address the underlying cause of the insomnia and attempt non-pharmacological interventions instead of using Seroquel for sleep.<br><br>When interviewed on 12/5/13, at 9:50 a.m. registered nurse (RN)-B stated she was aware R89's room mate was noisy and causing sleep problems for him. They had provided him with ear plugs, but she did not know if R89 used them or not. No other interventions had been placed to assist R89 with insomnia. She was not aware of any attempts to obtain a different room mate for R89.<br><br>A policy was requested, but not provided by the facility. | F 428 | | |
| F 441 SS=F | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections | F 441 | **F441 INFECTION CONTROL**<br><br>The policy entitled "Laundry" dated 12/4/13 has been updated to include the specific type of gown the laundry staff are to be wearing when sorting soiled linen. | 01/14/2014 |

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| F 441 | Continued From page 14<br>in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure soiled laundry was sorted in a manner to prevent the spread of infection. This practice had the potential to affect all 84 residents currently residing in the facility, who had their laundry or linens processed in the facilities laundry department.<br><br>Findings include: | F 441 | All staff handling soiled linen has been educated on the gowns to be worn when handling soiled linen.<br><br>Audits to assure compliance will be completed weekly x 4 weeks, then 2x monthly for 2 months, then quarterly x 1.<br><br>Audit results will be brought to the Quality Assurance Committee for review.<br><br>The EVS Manager/designee is responsible for maintaining compliance. | |

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| F 441 | Continued From page 15<br>During observation on 12/4/13, at 11:00 a.m. Laundry aide (LA)-A demonstrated how laundry is sorted using gloves and a gown. The gown was long sleeved and snapped up the front, it was made out of clothe. LA-A stated the gown is not impervious to liquids, but it gets changed out several times a day when it gets wet. LA-A verified her clothing under the gown could get wet and then contaminate clean items when she folds those. They use to have gowns impervious to liquid, but they were too hot to wear so they started using the cloth jackets quite some time ago.<br><br>When interviewed on 12/4/13, at 1:15 p.m. the environmental services manager stated laundry aides should be wearing clothing protection that is impervious to liquids to prevent clothing from becoming soiled with potential infectious material and passing this onto clean laundry.<br><br>A facility policy entitled Laundry, dated 12/4/13, included, "Linen shall be handled, stored and processed so as to control the spread of infection or disease." The policy indicated staff should use gowns when sorting linen, but did not specify if this gown should be impervious to fluids. | F 441 | | |

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

F5511022

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FORM APPROVED
OMB NO. 0938-0391

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| | 245511 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 12/04/2013 |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>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 THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>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.<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey the Centracare Health - Monticello Nursing 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.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES ( K-TAGS) TO:<br><br>HEALTH CARE FIRE INSPECTIONS<br>STATE FIRE MARSHAL DIVISION<br>444 CEDAR STREET, SUITE 145<br>ST. PAUL, MN 55101-5145, or | K 000 | POC ok<br>FS 1-3-14<br><br>RECEIVED<br>DEC 30 2013<br>MN DEPT. OF PUBLIC SAFETY<br>STATE FIRE MARSHAL DIVISION | |

DC: 1-14-14
EXIT: 12-5-13

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Gary Lanegran | Director of Facilities | 12/27/13 |

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<br>By e-mail to:<br>Barbara.lundberg@state.mn. us<br>and<br>Marian.Whitney@state.mn. us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br><br>The facility is a 2-story building with a Sub-basement built in 1986 and was determined to be of Type 11(222) construction. The facility is fully fire sprinkler protected and has a fire alarm system with smoke detection in corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 89 beds and had a census of 88 beds at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 011 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in | K 011 | | |

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| K 011 | Continued From page 2<br>corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2<br><br>This STANDARD is not met as evidenced by:<br>Observations revealed that there was a penetration in the fire barrier within the facility that did not meet the rated requirements for two hour fire separation and are not in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.1.1.4.3,. These deficient practices could allow the products of combustion to travel from one building to another, which could negatively affect the residents, staff and visitors of the facility.<br><br>Findings include:<br><br>On facility tour between 9:30 AM to 1:30 PM on 12/04/2013, observation revealed, that the 2 hour fire separation wall that is separating the hospital from the Care Center was found to have an 8 inch by 16 inch opening found above the ceiling tile that is located between the employee breakroom and the hospital Air Handling/Mechanical room. The opening that is passing through the 2 hours separation wall and is not sealed with an approved method for through penetration fir rate_d asse'llbl.<br><br>This deficient condition was confirmed by the Lead Engineer (TM). | K 011 | Opening was repaired and sealed using an approved method for repairing penetrations through a fire rated assembly to ensure a 2 hour separation wall. | 12/13/13 |
| K 022 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Access to exits is marked by approved, readily | K 022 | | |

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STATE FIRE MARSHAL DIVISION

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| K 022 | Continued From page 3<br>visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, the facility has failed to provide 8 of several operational exit signs that marks the means of egress path in accordance with NFPA Life Safety Code 101 (2000 edition), Sec. 7.10.1.7 and 7.10.8.1 These deficient practices could negatively affect all residents, staff and visitors, by causing confusion in locating an exit from the building to the public way in the event of an emergency.<br><br>Findings include:<br><br>On facility tour between 9:30 AM to 1:30 PM on 12/04/2013, the following deficient conditions were observed:<br><br>1. the exit signs located at both en9s of the 1st floor North Wing corridor were obscured by interior decorations,<br><br>2. the exit signs located at both ends of the 1st floor East Wing corridor were obscured by interior decorations,<br><br>3. the exit signs located at both ends of the 2nd | K 022 | | |

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| K 022 | 1 Continued From page 4<br>. floor North Wing corridor were obscured by interior decorations,<br><br>4. the exit signs located at both ends of the 2nd floor North Wing corridor were obscured by interior decorations, and<br><br>5. the doors located in the 1st floor resident dayroom lead into a enclosed courtyard that does not connect to the public way are not marked as "NO EXIT". These doors are not part of a required exit and needs to display a sign that reads as follows: NO EXIT. The word "NO" shall be in letters 2 inches in height and with a stroke width of 3/8 inch, and the word "EXIT' in letters 1 inch in height located directly below the word "NO".<br><br>This deficient condition was confirmed by the Lead Engineer (TM). | K 022 | All interior decorations were moved the day of the survey, to the satisfaction of the surveyor, so as to not obscure the exit signs at all noted locations.<br><br>~~12/04/13~~<br>12-5-13<br><br>A sign that reads "NO EXIT" was placed on 1st floor resident dayroom door, which complies with height and stroke width, as noted in 7.10.8.1 of the LSC.<br><br>~~12/04/13~~ | |
| K 029<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>One hour fire rated construction (with % hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smok_e res[sting pqrtiti_ons and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 | K 029 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245511 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 12/04/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CENTRACARE HEALTH - MONTICELLO | 1013 HART BOULEVARD<br>MONTICELLO, MN 55362 |

| (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 |
|---|---|---|---|---|
| K 029 | Continued From page 5<br><br>This STANDARD is not met as evidenced by:<br>Based on observations, the facility has failed to provide proper protection from 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. The following deficient practice could negatively affect the residents, staff, and visitors as smoke and fire in this rooms could enter the corridor making it untenable.<br><br>Findings include:<br><br>On facility tour between 9:30 AM to 1:30 PM on 12/04/2013, observation revealed, that there were several penetration in the wall above the corridor door located in the mechanical room #237 that were not sealed with an approved intumescent fire calking.<br><br>This deficient condition was confirmed by the Lead Engineer (TM). | K 029 | Wall penetrations in room #237 were sealed with an approved intumescent fire calking. 12/19/13 | |
| K 038 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to provide 5 of several doors of Egress in accordance with the following | K 038 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245511 | A. BUILDING 01 - MAIN BUILDING 01 B. WING | 12/04/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CENTRACARE HEALTH - MONTICELLO | 1013 HART BOULEVARD MONTICELLO, MN 55362 |

| (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 |
|---|---|---|---|---|
| K 038 | Continued From page 6<br>requirements of 2000 NFPA 101, Section 19.2.1 and 7.2.1.5.4, 7.2.1.6.1(d). The deficient practice could affect all 88 residents, staff, and visitors.<br><br>Findings include:<br><br>On facility tour between 9:30 AM to 1:30 PM on 12/04/2013, observation revealed the following deficient conditions:<br><br>1. the 1st floor North Wing stairwell has a egress magnetic lock on the door that does not have signs indicating how to operate coded keypad to release and exit through the magnetically locked exit doors,<br><br>2. the 1st floor East Wing stairwell has a egress magnetic lock on the door that does not have signs indicating how to operate coded keypad to release and exit through the magnetically locked exit doors,<br><br>3. the 2nd floor North Wing stairwell has a egress magnetic lock on the door that does not have signs indicating how to operate coded keypad to release and exit through the magnetically locked exit doors,<br><br>4. the 2nd floor East Wing stairwell has a egress magnetic lock on the door that doe not have signs indicating how to operate coded keypad to release and exit through the magnetically locked exit doors, and<br><br>5. The east exit located in the sub-basement storage room is blocked by storage and shelving units. | K 038 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245511 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 12/04/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CENTRACARE HEALTH - MONTICELLO | 1013 HART BOULEVARD<br>MONTICELLO, MN 55362 |

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|---|---|---|---|---|
| K 038 | Continued From page 7<br><br>This deficient condition was confirmed by the Lead Engineer (TM). | K 038 | Sign were posted at all exits indicating how to operate magnetic door coded keypad releasing devices.<br><br>Storage and shelving units blocking the east exit in the subbasement were moved to provide adequate means of egress. | 12/05/13<br><br>~~12/04/13~~ |

RJM CONSTRUCTION

# CHANGE REQUEST

TO: Mary Lanegran
CentraCare Health System
1406 6th Avenue North
St. Cloud, MN 56303
PH: 763-271-2207

FROM: Troy Stutz
PH: 952-893-8891 FAX: 952-832-9711
DATE: 11/18/13
PROJECT: CentraCare Monticello OB
CR: 11

**DESCRIPTION:** CR-011: Nursery Circ Board Drawer

**We are pleased to offer the pricing to make the following changes:**
CR-011: Nursery Circ Board Drawer

**Subcontractor/Vendor Performed Work:**

| Description | Subcontractor/Vendor | Cost Code | Price |
|---|---|---|---|
| Nursery Circ Board Drawer - Material | Wilkie Sanderson | 06-40-05 | $363.00 |
| Nursery Circ Board Drawer - Labor | Wilkie Sanderson | 06-40-05 | $193.00 |
| | | **Subcontract/Vendor Subtotal:** | $556.00 |
| | | **Subtotal:** | **$556.00** |
| | | **Total:** | **$556.00** |

The schedule is not affected by this change.

**RESPONSE DUE DATE:**

Approved By _____ Date _____

Company _____

**CC:**

**JOB:** 2013-07-0247

# WILKIE SANDERSON

1010 N. Summit Avenue
P.O. Box 250
Sauk Rapids, MN 56379

320-252-3165 Fax: 252-0673

Printed: 11/18/2013



## CHANGE REQUEST # 7891 - 9

Attn: Alyssa Fallon

Fax: 952-832-9600

RJM Construction
701 Washington Ave N, #600
Minneapolis, MN 55401

Date: 11/18/13
Project: CentraCare Health Monticello
1013 Hart Blvd.
Monticello, MN

## DESCRIPTION AND PRICING OF PROPOSED WORK ADD OR (DEDUCT)

| | REFERENCE: Rm 255A Nursery Drawer: | DOLLAR AMOUNT |
|---|---|---|
| 1 | Add to the base contract price to furnish one new plam face melamine drawer with interior | |
| 2 | melamine pull out surface, with built up edges and finger pull, per shop drawings included: | $363 |
| 3 | | |
| 4 | Alt. Price: labor to install drawer system on site, with removal of existing drawer: | $193 |
| 5 | (includes travel time) | |
| 6 | | |
| 7 | | |
| 8 | | |
| 9 | | |
| 10 | | |
| 11 | | |
| 12 | | |
| 13 | | |
| 14 | | |
| 15 | | |

THIS CONTRACT AMOUNT WILL BE INCREASED BY THIS CHANGE REQUEST: $556

RETURN THIS REQUEST TO WILKIE SANDERSON IMMEDIATELY. NONE OF THE ABOVE WORK WI LL BE MANUFACTURED UNTIL THIS APPROVED CHANGE REQUEST OR AN OFFICIAL CHANGE ORDER HAS BEEN RETURNED TO WILKE SANDERSON APPROVED.

IF AN OFFICIAL CHANGE ORDER CANNOT BE ISSUED BEFORE THE WORK IS REQUIRED, PLEASE INDICATE YOUR INTENT BY SIGNING BELOW.

SUBMITTED:

WILKIE SANDERSON

BY: Jim Dingmann

APPROVAL DATE: _____

CONTRACTOR: _____

BY: _____