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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TZ9C

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 **10/01/2014** (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 **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):

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 10/03/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 11/17/2014 (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
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
Posted 11/25/2014 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
09/24/2014 (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245485

October 3, 2014

Ms. Kathy Johnson, Administrator
Johnson Memorial Hospital & Home
1282 Walnut Street
Dawson, Minnesota 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 September 16, 2014 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
Division of Compliance Monitoring
Minnesota Department of Health
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
October 3, 2014

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

RE: Project Number S5485024

Dear Ms. Johnson:

On August 17, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 7, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On October 1, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 6, 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 August 7, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 16, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 7, 2014, effective September 16, 2014 and therefore remedies outlined in our letter to you dated August 17, 2014, 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
Division of Compliance Monitoring
Minnesota Department of Health
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	10/1/2014

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 **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **09/16/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/16/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **09/16/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **09/16/2014**	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	10/03/2014	28034	10/01/2014
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
8/7/2014			

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**	9/6/2014

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 Reg. # **NFPA 101** LSC K0045	Correction Completed **08/29/2014**	ID Prefix Reg. # **NFPA 101** LSC K0069	Correction Completed **08/13/2014**	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** PS/mm	**Date:** 10/03/2014	**Signature of Surveyor:** 22373	**Date:** 09/06/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 8/5/2014		**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: TZ9C

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 **08/07/2014** (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 **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 :
Tammy Williams, HFE NEII 09/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 09/23/2014 (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 :
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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
August 17, 2014

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

RE: Project Number S5485024

Dear Ms. Johnson:

On August 7, 2014, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

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 September 16, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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 imely. 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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 November 7, 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 February 7, 2015 (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 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 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 letter.

Sincerely,

Mark Meath

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

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 _____	08/07/2014

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 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164		9/16/14

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

Electronically Signed | 08/28/2014

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 _____	08/07/2014

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 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure specialized medical services remained confidential for 3 of 3 residents (R13, R14, R23) in the facility. Findings include: On 8/4/14, at 8:00 p.m. a maroon colored medical record binder, labeled with R13's name and room number was observed on the top shelf of a chart rack at the nursing station located at the entrance of the facility. The chart rack was located against the wall of the nursing station, which was open and visible upon entrance to the facility. The chart rack contained several maroon colored three ringed binders which held resident medical records. All of the binders were placed in the rack with the spine of the binder facing the nurses station. On the spine of R13's chart a label with the words, "Rice Hospice", written in bold black ink on a square shaped, bright green colored label located at the bottom of the spine of R13's medical record. On the same chart rack, another maroon colored medical record binder, labeled with R23's name and room number on the spine, included a rectangular bright green sticker label with printed words "Rice Hospice" in black. During observations on 8/5/14, and 8/6/14, R13	F 164	Residents R13, R14, and R23: Signage on the visible charts at nurse□s station 1 that specified hospital and hospice were removed from the outside of the resident□s charts. Other Residents: Director of Older Adult Services assessed all of the resident□s charts and no other resident□s chart specified any specialized medical services on the outside. Systemic Changes: No chart will specify any specialized medical services on the outside. Station assistant and nurses will be educated regarding HIPPA and confidentiality regarding resident□s medical charts. Education will occur during monthly staff meeting in September. Hospice will be specified by a hospice card on the inside of the chart. All other specialized medical services information will also remain inside the chart of each resident. Monitor: Station assistant will do a weekly audit for two months on Mondays to ensure resident information remains confidential.	

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F 164	Continued From page 2 and R23's charts were located on the chart rack at the nursing station with the labels present and visible. On 8/6/14, at 12:57 p.m. interview with the station assistant (SA)-A revealed it was the facility's usual practice to have labels on the residents' chart spines who receive Hospice care. The SA-A stated the labeling of the chart was done upon admission to hospice services. SA-A stated anyone who entered the facility via the front entrance was able to see all resident charts at the nursing station. SA-A further indicated the visitors had to pass by the nursing station in order to navigate the facility and therefore be able to see the residents' charts and who was receiving hospice services. On 8/6/14, 1:03 p.m. director of nursing (DON) verified the presence of the hospice labels and stated she had questioned this practice in the past as a possible violation of privacy. However as this was the facilities practice no change had been made. DON also verified anyone who entered the facility would have to pass the nursing station, thus were able to see resident charts and be able to identify R13 and R23's as receiving hospice services. During observation on 8/5/14, at 4:13 p.m. R14's medical chart was observed to have a white sign on the spine of the chart with hand written black letters, "Hosp.," identifying R14 was in the hospital. The white piece of paper covered R14's name, however, did not cover R14's room number. During an interview on 8/6/14, at 12:55 p.m. SA-A confirmed the facility placed the sign on the spine of R14's medical record. SA-A also confirmed the	F 164	Then do the same audit monthly on the first Monday of the month for four more months. Reports of the audits will be taken to QA on a quarterly basis for review and possible suggestions. Completion Date: September 16, 2014.	

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F 164	Continued From page 3 sign was highly visible to anyone walking by the nurses station, which was located directly inside of the main entrance to the facility. The SA stated due to the room number not being covered up by the sign, R14 would still be identified as the names are placed at each room. During interview on 8/6/14, at 1:00 p.m. the director of nursing (DON) confirmed the sign should not have been placed on the spine of R14's medical record. DON confirmed the medical records located on the two chart racks directly behind the nurses station would be visible to anyone who would pass by the nurses' station. The facility's Storage of Active Medical Record In The Care Center policy dated 5/02, directed all charts were expected to be secured and confidential.	F 164		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the wound treatment care plan for 1 of 1 resident (R2) reviewed for pressure ulcers. Findings include: The physician's orders dated 8/7/14, identified	F 282	Resident R2: Wound Care Nurses corrected the orders and the treatment sheets to match the wound care that was actually being completed. Other Residents: There were no other residents affected as	9/16/14

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F 282	Continued From page 4 R2's diagnoses to include decubitus ulcer, diabetes mellitus, severe multiple sclerosis, osteomyelitis, total urethral necrosis. The orders directed to cleanse right R2's buttock wound with NACL (sodium chloride wound cleanser) twice daily and as needed, to pack the wound with gauze, apply skin prep to the surrounding skin, apply calmo (an ointment) and cover with ABD (abdominal pad); orders further directed to cleanse R2's labia with NACL, cover with NACL, apply bactroban (an antibacterial ointment), and cover the area with KerraMax dressing (a super-absorbent heavy exudate dressing) every shift. The care plan dated 6/4/14, identified R2 had pressure ulcers, was immobile due to MS and dependent on staff for all bed mobility and repositioning. R2 was identified to have a stage four pressure ulcer on the right buttock, was identified as high risk for pressure ulcers; R2 was always incontinent with interventions of, but not limited to: dressing change to existing pressure ulcers as ordered per MD, see nursing treatment sheet for current treatment plan. The care plan did not identify changes to R2's wound treatment. During observation of a stage four wound dressing treatment on 8/6/14, at 7:27 a.m. registered nurse (RN)-A was observed to wash hands and apply gloves appropriately. RN-A removed the old dressing from the right buttock wound, removed her gloves and washed her hands appropriately (hand hygiene) and then cleansed R2's buttocks with Tena wash cream and a wash cloth. RN-A pat dried the area with a clean cloth, performed appropriate hand hygiene and cleansed the right buttock area with NACL. After hand hygiene RN-A cut gauze packing,	F 282	there are no other residents with pressure ulcers at this time. Systemic Changes: Once a new order is initiated regarding the treatment of a pressure ulcer, the skin care nurses will visually confirm that the orders and the treatments match. If the order and treatments performed do not match at any time, wound care nurses/nurse performing wound care will clarify the order so they match. Education will be done at our September nurse's meeting regarding wound care orders as well as changing and transcribing orders protocol. Monitor: Weekly audit performed by one nurse comparing orders to what treatment is actually being done for two months and then monthly for four months. Reports of the audits will be taken to QA on a quarterly basis for review and possible suggestions. Completion Date: September 16, 2014	

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F 282	Continued From page 5 applied Aquaphore ointment into gauze packing and placed the packing into the right buttock wound. RN-A was further observed to swab betadine around the outside of the right buttock wound skin surface. After hand hygiene, RN-A cleansed R2's labia with NACL, applied Aquaphore ointment to labia skin area, performed hand hygiene and then covered the right buttock and labia wounds with sorbalgon calcium alginate dressing, applied and ABD pad with tape. RN-A then applied calmo to buttocks, then performed hand hygiene. - Although RN-A performed appropriate hand hygiene during the observation, the dressing change did not match the treatment directed by the physician's orders. Such as R2 did not have an order to apply Aquaphore ointment to gauze packing for right buttock wound, to apply betadine around outside of right buttock wound, to apply a sorbalgon calcium alginate dressing over the right buttock wound or an order to apply Aquaphore ointment to labia instead of bactroban ointment. At the time of the observation, RN-A verified the findings and stated, "Usually our physician will let us decide what to do for dressing change, as we are wound care nurses." An undated note provided by the facility, indicated since 2012 Johnson Memorial Health Services has two fully qualified and certified wound care nurses. The two nurses were identified as RN-A and RN-B. The note indicated the two nurses were "empowered to write orders for skin care and wound care patients" and residents of Johnson Memorial Health Services. The note was signed by the medical director. However R2's physician orders had no orders written to indicate a change in wound treatment orders from the current physician orders dated 8/7/14.	F 282		

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F 282	Continued From page 6 On 8/7/14, at 8:27 a.m. when registered nurse (RN)-B was asked what the process was when a wound care nurse decided a change in wound treatment was needed, RN-B stated first a skin assessment should be completed, then "get a hold of the provider" and explain "why we would like to make changes to the dressing change." RN-B stated if the provider approved the changes, the facility would "obtain an order" for the change from the provider and inform other staff of the change. On 8/7/14, at 9:16 a.m. the director of nursing (DON) stated it was the DON's expectation staff would follow exactly what was on the orders for wound treatments, or if non-prescription would write the nursing order for it. DON stated they would expect the wound care nurses to notify the physician of any changes made to wound treatment dressing changes. At the time a policy for physician orders was requested, but none was provided.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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	F 314		9/16/14

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F 314	Continued From page 7 by: Based on observation, interview and document review, the facility failed to provide the ordered wound dressing treatment to prevent the potential progression of a pressure ulcer for 1 of 1 resident (R2) reviewed for pressure ulcers. Findings include: R2's quarterly Minimum Data Set (MDS) dated 6/3/14, identified R2 was cognitvely intact and required total assistance with all activities of daily living (ADL's). The MDS indicated R2 did have a stage four pressure ulcer, which was present on admission. The physician's orders dated 8/7/14, identified R2's diagnoses to include decubitus ulcer, diabetes mellitus, severe multiple sclerosis (MS), and osteomyelitis. The orders directed to cleanse right R2's buttock wound with NACL (sodium chloride wound cleanser) twice daily and as needed, to pack the wound with gauze, apply skin prep to the surrounding skin, apply calmo (an ointment) and cover with ABD (abdominal pad); orders further directed to cleanse R2's labia with NACL, cover with NACL, apply bactroban (an antibacterial ointment), and cover the area with KerraMax dressing (a super-absorbent heavy exudate dressing) every shift. During observation of a stage four wound dressing treatment on 8/6/14, at 7:27 a.m. registered nurse (RN)-A was observed to wash hands and apply gloves appropriately. RN-A removed the old dressing from the right buttock wound, removed her gloves and washed her hands appropriately (hand hygiene) and then cleansed R2's buttocks with Tena wash cream	F 314	Resident R2: Wound Care Nurses corrected the orders and the treatment sheets to match the wound care that was actually being completed. Other Residents: There were no other residents affected as there are no other residents with pressure ulcers at this time. Systemic Changes: Once a new order is initiated regarding the treatment of a pressure ulcer, the skin care nurses will visually confirm that the orders and the treatments match. If the order and treatments performed do not match at any time, wound care nurses/nurse performing wound care will clarify the order so they match. Education will be done at our September nurse's meeting regarding wound care orders as well as changing and transcribing orders protocol. Monitor: Weekly audit performed by one nurse comparing orders to what treatment is actually being done for two months and then monthly for four months. Reports of audits will be taken to QA on a quarterly basis for review and possible suggestions. Completion Date: September 16, 2014	

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F 314	Continued From page 8 and a wash cloth. RN-A pat dried the area with a clean cloth, performed appropriate hand hygiene and cleansed the right buttock area with NACL. After hand hygiene RN-A cut gauze packing, applied Aquaphore ointment into gauze packing and placed the packing into the right buttock wound. RN-A was further observed to swab betadine around the outside of the right buttock wound skin surface. After hand hygiene, RN-A cleansed R2's labia with NACL, applied Aquaphore ointment to labia skin area, performed hand hygiene and then covered the right buttock and labia wounds with sorbalgon calcium alginate dressing, applied and ABD pad with tape. RN-A then applied calmo to buttocks, then performed hand hygiene. - Although RN-A performed appropriate hand hygiene during the observation, the dressing change did not match the treatment directed by the physician's orders. Such as R2 did not have an order to apply Aquaphore ointment to gauze packing for right buttock wound, to apply betadine around outside of right buttock wound, to apply a sorbalgon calcium alginate dressing over the right buttock wound or an order to apply Aquaphore ointment to labia instead of bactroban ointment. At the time of the observation, RN-A verified the findings and stated, "Usually our physician will let us decide what to do for dressing change, as we are wound care nurses." R2's Treatment Sheet dated 8/14, directed to cleanse the right wound with NACL BID (twice daily) and PRN (as needed), pack with gauze, apply skin prep to surrounding skin, apply calmo and cover with ABD and cleans labia with NACL and apply Aquaphor and cover with Kerramax dressing every shift. A line had been drawn through the words "cover with NACL" and the	F 314		

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F 314	Continued From page 9	F 314		

word "bactroban," Aquaphor had been hand written in above bactroban. Although these changes were made on R2's Treatment Sheet, the physician orders dated 8/7/14, did not indicate the above noted changes.

The care plan dated 6/4/14, identified R2 had pressure ulcers, was immobile due to MS and dependent on staff for all bed mobility and repositioning. R2 was identified to have a stage four pressure ulcer on the right buttock, was identified as high risk for pressure ulcers; R2 was always incontinent with interventions of, but not limited to: dressing change to existing pressure ulcers as ordered per MD, see nursing treatment sheet for current treatment plan. The care plan did not identify changes to R2's wound treatment.

R2's Wound Assessment Report dated 8/1/14, identified stage four pressure ulcer right buttock measured: length 2.00 cm (centimeters), width 0.80 cm and depth 0.70 cm, wound bed epithelial tissue 75 percent, slough 25 percent and wound edges border definition distinct, outline clearly visible and description macerated.

An undated note provided by the facility, indicated since 2012 Johnson Memorial Health Services has two fully qualified and certified wound care nurses. The two nurses were identified as RN-A and RN-B. The note indicated the two nurses were "empowered to write orders for skin care and wound care patients" and residents of Johnson Memorial Health Services. The note was signed by the medical director. However R2's physician orders had no orders written to indicate a change in wound treatment orders from the current physician orders dated 8/7/14.

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F 314	Continued From page 10 On 8/7/14, at 8:27 a.m. when registered nurse (RN)-B was asked what the process was when a wound care nurse decided a change in wound treatment was needed, RN-B stated first a skin assessment should be completed, then "get a hold of the provider" and explain "why we would like to make changes to the dressing change." RN-B stated if the provider approved the changes, the facility would "obtain an order" for the change from the provider and inform other staff of the change. On 8/7/14, at 9:16 a.m. the director of nursing (DON) stated it was the DON's expectation staff would follow exactly what was on the orders for wound treatments, or if non-prescription would write the nursing order for it. DON stated they would expect the wound care nurses to notify the physician of any changes made to wound treatment dressing changes. At the time a policy for physician orders was requested, but none was provided.	F 314		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		9/16/14

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F 441	Continued From page 11 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper infection control practices were implemented to prevent the potential spread of infection and blood borne pathogens, when transporting linens visibly soiled with blood. This practice had the potential to affect all 52 residents residing in the facility and facility staff. Findings include: During observation on 8/6/14, at 7:27 a.m. registered nurse (RN)-A had cleansed R2's	F 441	Resident R2: Re-educated staff member on blood borne pathogens and proper PPE use. Other Residents: There were no other residents affected. Systemic Changes: Educate all staff members on blood borne pathogens and proper PPE use to prevent contamination of residents and personnel at our monthly staff meeting in September. Require all staff to complete	

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F 441	Continued From page 12 buttocks with Tena wash cream and had used a clean hand towel to pat dry the skin on R2's buttocks. R2's buttocks had an area of irritated red skin that was bleeding when RN-A patted the skin dry with a hand towel, causing visible blood to be on the hand towel. At 7:48 a.m. nursing assistant (NA)-A carried the hand towel with visible blood out of R2's room with bare hands (no gloves on). NA-A carried the blood soiled hand towel down the hallway and placed the hand towel in a plastic bin for soiled linens. NA-A had not placed the hand towel with visible blood in a plastic bag to transport from R2's room down the hallway and had placed the towel in a bin used for other soiled linens. NA-A verified at the time. On 8/6/14, at 1:42 p.m. the director of nursing (DON) stated she expected staff to "definitely" wear gloves when handling blood soiled linens. DON stated usually if blood were on linens, staff would have to handle the linens differently than, "Just throwing" the blood soiled linens in the linen bins. DON stated, "They would have to be bagged separate." Document review of the facility policy INFECTION CONTROL LINEN dated 7/14, read "POLICY: Linen will be handled in a way so as to prevent contamination with dirty linen and maintain cleanliness of clean linen. PURPOSE: To collect dirty linen and prevent contamination of residents and personnel. To store clean linen and prevent contamination. PROCEDURE: 9. If linen or clothing has blood on it, put in impervious clear plastic bag, take directly to laundry and notify laundry staff of blood. b. Use disposable gloves when handling bloody linens."	F 441	the Healthcare Academy lessons Breaking the chain of infection and Understanding blood borne pathogens by September 30, 2014. Monitor: The nurses will complete an observational audit of five staff following proper blood borne pathogens and infection control technique weekly for two months and then monthly for four months.Reports of the audits will be taken to QA on a quarterly basis for review and possible suggestions. Completion Date: September 16, 2014.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245485	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/05/2014**

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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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 August 5, 2014. 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		08/28/2014

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 **01 - MAIN BUILDING 01** B. WING _____	**08/05/2014**

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JOHNSON MEMORIAL HOSP & HOME	**1282 WALNUT STREET** **DAWSON, MN 56232**

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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 53 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in	K 045		8/29/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245485	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/05/2014**

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K 045	Continued From page 2 darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, a required exit discharge in the means of egress was not illuminated in accordance with NFPA 101 (2000), Chapter 19, Section 19.2.8. and Chapter 7, Section 7.8. In an emergency evacuation situation, this deficient practice could adversely affect 18 of 53 residents. FINDINGS INCLUDE: On 08/05/2014 at 1:50 PM, observation revealed the exterior exit discharge from the horizontal exit from the West Corridor was not equipped with a two-bulb light fixture(s), to provide illumination of the means of egress from the building to the public way. This arrangement was not in accordance with the requirements at NFPA 101 (00) Chapter 7, Section 7.8. This finding was verified with the chief building engineer at the time of discovery.	K 045	Put a 2 bulb exit light outside the exit discharge. It has a photo eye so it comes on at night and is connected to the emergency power panel. Will be done by 8/29/14. Scott Ochsendorf, Facilities Manager	
K 069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide a portable extinguisher of the proper classification in the commercial kitchen, in	K 069	Purchased K-Class extinguisher and put in kitchen on 8/13/14. Scott Ochsendorf, Facilities Manager	8/13/14

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K 069	Continued From page 3 accordance with the requirements at NFPA 96 (1998) Chapter 7, Section 7-10 and NFPA 10 (1998) Chapter 3, Section 3-7. This deficient practice could adversely affect 26 of 56 residents. FINDINGS INCLUDE: On 08/05/2014 at 2:10 PM, during an inspection of the facility's commercial kitchen, no portable Class-K fire extinguisher could be located. This finding was confirmed with the chief building engineer.	K 069		

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 17, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5485024

Dear Ms. Johnson:

The above facility was surveyed on August 4, 2014 through August 7, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson by phone at (218) 332-5140 or email: gail.anderson@state.mn.us

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

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

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