



NIXON PEABODY LLP
ATTORNEYS AT LAW

NIXONPEABODY.COM
@NIXONPEABODYLLP

EDWARD CLANCY
Counsel
T: 312-977-4487
eclancy@nixonpeabody.com

70 West Madison Street
Suite 3500
Chicago, Illinois 60602
O: 312-977-4400
F: 844-556-0737

April 5, 2017

Via Federal Express

Courtney Avery, Administrator
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

RECEIVED

APR 06 2017

**HEALTH FACILITIES &
SERVICES REVIEW BOARD**

Re: Pana Community Hospital; Project No. 17-007

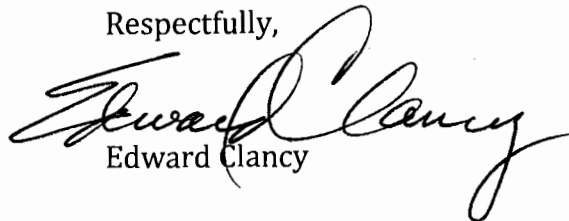
Dear Ms. Avery:

In response to the State Board reviewer's comments on Applicants' application for a certificate of need permit for the referenced Project ("Application"), I enclose modified pages to the Application, along with Katrina Casner's original signature to the Assurances page in Attachment 15.

Please insert these pages into the Application in place of the current pages. This modification of the Application is in conformance with and limited to the reviewer's comments, recommendations, or objections to the Application.

I appreciate your help. If you have any questions or need any additional information, please contact me.

Respectfully,



Edward Clancy

Enclosures

cc: Trina Casner (w/ encl.) (via email)

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must equal.

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	5,901	8,484	14,385
Site Survey and Soil Investigation	6,225	9,211	15,436
Site Preparation	126,770	187,571	314,341
Off Site Work			
New Construction Contracts	5,754,841	7,762,371	13,517,212
Modernization Contracts	638,514	1,430,600	2,069,114
Contingencies	397,296	571,269	968,565
Architectural/Engineering Fees	648,940	933,108	1,582,048
Consulting and Other Fees	354,643	509,939	864,582
Movable or Other Equipment (not in construction contracts)	428,240	412,339	840,579
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)	65,630	94,370	160,000
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
TOTAL USES OF FUNDS	8,427,000	11,919,262	20,346,262
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	4,906,476	6,939,786	11,846,262
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages	3,520,524	4,979,476	8,500,000
Leases (fair market value)			
Governmental Appropriations			
Grants			
Other Funds and Sources			
TOTAL SOURCES OF FUNDS	8,427,000	11,919,262	20,346,262
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT-7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

M. Criterion 1110.3030 - Clinical Service Areas Other than Categories of Service

1. Applicants proposing to establish, expand and/or modernize Clinical Service Areas Other than categories of service must submit the following information:

2. Indicate changes by Service: Indicate # of key room changes by action(s):

Service	# Existing Key Rooms	# Proposed Key Rooms
☒ Diagnostic Imaging*	3	3
☒ Lab**	3	3
☒ Ambulatory Care Services***	0	4

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

Project Type	Required Review Criteria
New Services or Facility or Equipment	(c) - Need Determination - Establishment
Service Modernization	(d)(1) - Deteriorated Facilities
	AND/OR
	(d)(2) - Necessary Expansion
	PLUS
	(d)(3)(A) - Utilization - Major Medical Equipment
	OR
	(d)(3)(B) - Utilization - Service or Facility
APPEND DOCUMENTATION AS ATTACHMENT 31, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

* Includes bone density, mammography, and ultrasound. CT and general radiology are not being modernized.

** There previously was two general lab rooms and one phlebotomy room. The propose lab will have one general lab room, one phlebotomy room, and one microbiology room.

*** Includes three exam rooms and one triage room.

M. Criterion 1110.3030 - Clinical Service Areas Other than Categories of Service

1. Applicants proposing to establish, expand and/or modernize Clinical Service Areas Other than categories of service must submit the following information:
2. Indicate changes by Service: Indicate # of key room changes by action(s):

Service	# Existing Key Rooms	# Proposed Key Rooms
☒ Emergency Services/Trauma*	6	5
☒ Surgery	2	2
☒ Nuclear Medicine	1	1

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

Project Type	Required Review Criteria
New Services or Facility or Equipment	(c) - Need Determination - Establishment
Service Modernization	(d)(1) - Deteriorated Facilities
	AND/OR
	(d)(2) - Necessary Expansion
	PLUS
	(d)(3)(A) - Utilization - Major Medical Equipment
	OR
	(d)(3)(B) - Utilization - Service or Facility
APPEND DOCUMENTATION AS ATTACHMENT 31, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

* Proposed key rooms includes three exam rooms. The two trauma rooms will remain the same.

Assurances

March 23, 2017

In accordance with 77 Ill. Adm. Code § 1110.234, to my understanding, I attest that by the end of the second year of operation after the proposed project completion, the Applicant will meet or exceed the utilization standards specified in 77 Ill. Adm. Code § 1110. Appendix B.

Katrina Casner

Katrina Casner, CEO and President
Pana Community Hospital Association

Subscribed and sworn to before me this 23rd day of March 2017

Kelly S. Reed

Signature of Notary

Seal



Page 54-A

Statement of Deficiencies and Hospital IDPH Plan of Correction
For February 22, 2016 Survey

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 000	INITIAL COMMENTS On February 22, 2016 the Life Safety Code portion of a Sample Validation Survey was conducted. The surveyors were accompanied during the survey walk-through by the following staff: Facility Director - F.D. President and Chief Executive Officer - C.E.O. The facility was observed to consist of an original building with a series of additions. 1. The Original Building, constructed in 1913, consisting of 3 stories plus a basement. The building is partially sprinkler protected. 2. The 1955 Addition, consisting of 3 stories plus a basement. The addition is partially sprinkler protected. 3. The Center Addition, constructed in 1978, consisting of a Stair and elevator is 3 stories plus a mechanical penthouse and a basement. 5. The Emergency Department Addition, constructed in 2000, consisting of 1 story plus a basement. The addition was observed to be of Type I (332) construction. The addition is covered by a automatic sprinkler system. 6. The Rehabilitaion and Wellness Center is a separate building on the Hospital campus. It is a single story slab on grade non sprinklered building of construction type II (000). Unless otherwise noted, those code sections listed herein that do not include a reference to a	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

02/22/2016

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.

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 000	Continued From page 1 specific NFPA code and year of issue (such as NFPA 70 1999) are taken from the 2000 Edition of the NFPA 101 Life Safety Code. Unless otherwise noted, all deficiencies cited herein were found through observation during the survey walk-through, staff interview, or document review. The requirements of 42 CFR Subpart 485.623, Physical Environment, are NOT MET as evidenced by the deficiencies cited under the following K-Tags.	K 000			
K 012	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation the facility failed to provide components of a building's designated construction type. This condition could affect individuals on the floor of fire incident from safely traveling the means of egress to the nearest exit stair and to a discharge on another floor. Finding include: On 02/22/2016 at 10:00 am, 3rd floor Center stair, the surveyor observed while accompanied by the facility F.D. and C.E.O., portions of the hospital which contain unprotected structural steel beams. This does not comply with the minimum construction type requirements of 19.1.6.2 and NFPA 220, 1999 Edition.	K 012			
K 020	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings	K 020			

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 020	Continued From page 2 between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observations the facility failed to maintain properly rated shaft enclosures. This deficient practice could affect patients, staff and visitor if smoke and fire were allowed to expand from other areas of the facility through deficient shaft enclosures. Findings include: On 02/22/2016 at 10:15am, the surveyor, while accompanied by the C.E.O. and F.D. observed an access panel located in a 2-hour fire rated shaft. The framed-in opening did not contain a fire resistant rating. This condition does not comply with 18.3.1 and 8.2.5.2 for a continuous fire rated protected enclosure of the shaft wall. Location observed: 3rd floor surgery waiting room closet.	K 020			
K 021	NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed	K 021			

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 021	Continued From page 3 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. This STANDARD is not met as evidenced by: By direct observation/staff interview the surveyor finds the facility failed to install a means to automatically close the fire shutter separating the kitchen from the corridor. This deficient practice could result in the failure / response during a fire event, which may affect patients, staff and visitors. On 2/22/16 at 2:30PM in the company of the Chief Executive Officer, the surveyor finds that the fire shutter was being held open by a fusible link only and would not released to close by manual fire alarm operation or local smoke detection to comply with NFPA 72 1999 edition 2-10.6.	K 021			
K 029	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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 smoke resisting partitions 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 This STANDARD is not met as evidenced by:	K 029			

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 4 Based on observation the facility failed to provide complete separation between hazardous areas and the remainder of the building. These deficiencies could affect all patients within the smoke compartment, as well as any staff and visitors present, by allowing smoke and fire to escape from hazardous rooms into the exit access in the event of a fire condition. Findings include: A. On 02/22/2016 at 1:15 pm, 2nd floor, while accompanied by the F.D. and C.E.O, the surveyor observed a storage room (formerly patient room which is located across from the nurse station) which contains equipment and combustible materials that does not comply with 19.3.2.1 (7) and 8.4.1.3 for an adequate separation provided by a fire resistant self closing door and frame. The room lacks a 1-hour fire resistant enclosure to be shown on the facility life safety floor plans. B. On 02/22/2016 at 2:30 pm, Basement, while accompanied by the F.D. and C.E.O., the surveyor observed clean storage, material management, laundry room all connected with ceiling areas open to each other. C. On 02/22/2016 at 2:00 pm, 1st floor Emergency Department, while accompanied by the F.D. and the C.E.O., the surveyor observed equipment and linens stored in a corridor alcove. The amount of combustibles deems it a hazardous area which is not separated from a means of egress corridor. D. On 02/22/2016 at 2:10am, 1st floor Pharmacy room, while accompanied by the F.D. and the	K 029			

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 C.E.O., the surveyor observed a designated hazardous area (due to the amount of storage) which is sprinkler protected located adjacent to an office space, the office space does not comply with 8.4.1.3 due to the following: 1. The room did not appear to be sprinkler protected. 2. The room did not appear to have a fire rated separation from the pharmacy due to the lack of a fire rated door and frame.	K 029			
K 034	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4 This STANDARD is not met as evidenced by: Based on observation the facility failed to provide exit stairs constructed to provide a safe means of egress to a discharge. These deficiencies could affect any patients, staff, or visitors in the stair during a building or floor evacuation. Findings include: On 02/22/2016 at 10:00 am while accompanied by the F.D. and C.E.O., the surveyor observed stair landings which lack a continuous toe plate which are to prevent a person from tripping over the edge of a stair landing during vertical egress. The current condition does not comply with subpart (3) to 7.2.2.4.6.	K 034			
K 046	Example location observed, the "center" stair leading to the mechanical penthouse. NFPA 101 LIFE SAFETY CODE STANDARD	K 046			

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 046	Continued From page 6 Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. This STANDARD is not met as evidenced by: Based on document review the facility does not maintain proper records of required testing. This could effect anybody having surgery if the battery lights did not work upon loss of power. Findings include: On 2/22/16 at 2:45 pm, the surveyor observed during document review, while accompanied by the CEO and the FD, that records were not available showing that battery lights were tested for 30 seconds each month and for 90 minutes annually in accordance with the 2000 Edition of NFPA-101, Section 7.9.3.	K 046			
K 047	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: Based on observation the facility failed to provide exit signs that are fully visible, or incorrectly identify paths of egress. This deficiency may affect all patients within the areas of the facility, as well as any staff and visitors present, by preventing those occupants from readily utilizing an available exit during a fire or smoke event. Findings include:	K 047			

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 047	Continued From page 7 On 2/22/2016 at 2:45 pm, surveyor observed, while accompanied by the facility F.D. and C.E.O., basement level exit signs are not provided to identify the 2nd means of egress to comply with 19.2.5.9, 19.2.5.10 and 7.10. Locations noted include the following: 1. Meeting room exit signage not clearly visible. 2. Exit path leading to Center stair not clearly visible.	K 047			
K 051	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6	K 051			

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 051	Continued From page 8 This STANDARD is not met as evidenced by: Based on observation, the fire alarm panels are not properly labeled. This could effect facility maintenance staff if power is lost to the system. Findings include: On 2/22/16 at 9:30 am, while accompanied by the CEO and the FD, the surveyor observed the fire alarm panels located in the lower level conference room and the elevator lobby were not labeled with the life safety panel and circuit serving them in accordance with the 1999 Edition of NFPA-72, Section 1-5.2.5.2.	K 051			
K 067	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide a completely enclosed ventilation system. This deficient practice could result in the failure / response during a fire event, which may affect patients, staff and visitors. Finding includes: On 02/22/2016 at 10:30am, 2nd floor, while accompanied by the facility F.D. and C.E.O., the surveyor observed a duct penetration through the fire rated smoke barrier which was not installed as required by the duct/damper manufacturer. Location observed above the ceiling at the pair of cross corridor doors leading into surgery. This installation does not comply with 19.3.7.3 exception no. 2 and NFPA 90A.	K 067			

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 077	NFPA 101 LIFE SAFETY CODE STANDARD Piped in medical gas systems comply with NFPA 99, Chapter 4. This STANDARD is not met as evidenced by: By direct observation, the facility failed to correctly install / maintain the piped medical gas system. This deficient practice could result in the response during a fire event, which may affect patients, staff and visitors. A. On 2/22/16 at 11:00AM in the company of the Chief Executive Officer, the surveyor finds the medical gas zone valves serving the 1913 second floor patient room rooms are installed behind a normally open cross corridor door hidden from plain view in noncompliance with NFPA 99, 1999 4-3.1.2.3 (i). B. On 2/22/16 at 10:00AM in the company of the Chief Executive Officer, the surveyor finds the facility medical gas zone valves identification serving the 2nd and 3rd floor rooms outlets/inlets have not been updated to reflect renovation changes and the abandonment of outlets/inlets. NFPA 99, 1999, 4-3.1.2.14 (b) 3	K 077			
K 106	NFPA 101 LIFE SAFETY CODE STANDARD Hospitals and inpatient hospices with life support equipment have an Type I Essential Electric System, and nursing homes have a Type II ESS that are powered by a generator with a transfer switch and separate power supply in accordance with NFPA 99. 12-3.3.2, 13-3.3.2.1, 16-3.3.2 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation, the facility failed to to maintain a proper emergency power system. If the generator fails to operate upon the loss of normal power, this could effect all occupants of the building.	K 106			

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 106	Continued From page 10 Findings Include: A. On 2/22/16 at 11:00 am, while accompanied by the CEO and the FD, the surveyor observed that the generator annunciators were either missing or deficient. 1. The Onan generator was not equipped with a remote annunciator. 2. The Detroit generator annunciator did not meet the requirements of the 1999 Edition of NFPA-99, Section 3-4.1.1.15, and the 1999 Edition of NFPA-110, Table 3-5.5.2(d). B. On 2/22/16 at 2:00 pm, while accompanied by the CEO and the FD, the surveyor observed the batteries serving the generators were in unheated enclosures and were not equipped with battery heaters to meet the requirements of the 1999 Edition of NFPA-110, Section 3-3.1. C. On 2/22/16 at 2:00 pm, while accompanied by the CEO and the FD, the surveyor observed the battery charger for the batteries of the Onan generator was not connected in accordance with the requirements of the 1999 Edition of NFPA-110, Section 5-12.6.	K 106			
K 130	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: A. Due to the number, variety, and severity of the life safety code deficiencies observed during the survey walk-through, the provider shall institute appropriate interim life safety measures until all cited deficiencies are corrected. The provider shall include, as an attachment to its	K 130			

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 130	Continued From page 11 Plan of Correction (PoC) and referenced therein, a detailed narrative and proposed schedule for all such measures. The narrative shall describe all measures to be implemented, as well as the frequency with which they are to be conducted, and shall indicate the manner in which the measures are to be documented. The narrative shall also include comments related to changes in the interim life safety measures to remain in place as work toward the completion of its PoC progresses. B. On 02/22/2016 at 12:45 pm, 1st floor negative pressure patient room ante room, the surveyor observed while accompanied by the F.D. and C.E.O., a faucet mounted temperature pressure regulator installed over a sink which does not comply with ANSI Z358.1-1998.	K 130			
K 145	NFPA 101 LIFE SAFETY CODE STANDARD The Type I EES is divided into the critical branch, life safety branch and the emergency system and Type II EES is divided into the emergency and critical systems in accordance with 3-4.2.2.2, 3-5.2.2 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation, the emergency power was not properly divided into three branches. This could effect all occupants of the building if the emergency power failed to operate properly upon loss of normal power. Findings include: On 2/22/16 at 10:45 am, while accompanied by the CEO and the FD, the surveyor observed that all panels serving the second floor were served from one of the two emergency generators and all	K 145			

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 145	Continued From page 12 panels were serving a mix of life safety, critical and equipment loads. This was not in compliance with the 1999 Edition of NFPA-70, Sections 517-30 through 517-35. Examples: 1. Panel EM2A serves a mix of critical and equipment loads. 2. Panel L3A serves a mix of critical and equipment loads. 3. Panel marked as Onan generator serves a mix of all branches of emergency power.	K 145			
K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide a proper electrical system. This could effect any patient if a transfer switch failed. Findings include: A. On 2/22/16 at 10:00 am, while accompanied by the CEO and the FD, the surveyor observed the following areas were not equipped with normal power receptacles or receptacles served from two separate critical transfer switches as required by the 1999 Edition of NFPA-99, Section 3-3.2.1.2(a)1. 1. The operating rooms 2. The stage 1 recovery rooms 3. All patient rooms B. On 2/22/16 at 1:30 pm, while accompanied by	K 147			

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 147	Continued From page 13 the CEO and the FD, the surveyor observed that the elevator equipment room was not equipped with a lighting disconnect served from the life safety branch of emergency power in accordance with the 1999 Edition of NFPA-70, Section 620-22, and Section 517-32.	K 147			
K 160	NFPA 101 LIFE SAFETY CODE STANDARD Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators & Escalators. All existing elevators, having a travel distance of 25 ft or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. 9.4.2, 9.4.3, 19.5.3 (Includes firefighters service phase I key recall and smoke detector automatic recall, firefighters service phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide an elevator recall system. This could effect anybody using the elevator during a fire. Findings include: On 2/22/16 at 2:30 pm, while accompanied by the CEO and the FD, the surveyor observed that the elevators were not equipped with a recall system to meet the requirements of ANSI/ASME A 17.1.	K 160			

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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	

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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	
C 000	INITIAL COMMENTS The life safety code portion of a sample validation survey was conducted on February 22, 2016. We recommend the requirements of 42 CFR Subpart 485.623, Physical Environment, are not met. A sample validation survey for health standards was conducted on 2/22/2016 through 2/25/2016. The Critical Access Hospital (CAH) was not in compliance with Standards for CAH, 42 CFR 485, as evidenced by:	C 000			
C 220	485.623 PHYSICAL PLANT AND ENVIRONMENT Physical Plant and Environment	C 220			
C 231	This CONDITION is not met as evidenced by: Based on observation, staff interview and document review during the life safety code portion of the recertification survey conducted on February 22, 2016, the surveyor finds that the facility is not constructed and maintained as a safe environment for patients. See Tag C0231 485.623(d)(1) LIFE SAFETY FROM FIRE- NFPA Except as otherwise provided in this section-- (i) the CAH must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. A copy of the Code is available for inspection at the CMS	C 231			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

02/25/2016

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.

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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	
C 231	Continued From page 1 Information Resource Center, 7500 Security Boulevard, Baltimore, MD, or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal-regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. (ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the Life Safety Code does not apply to a CAH. After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code that, if rigidly applied, would result in unreasonable hardship on the CAH, but only if the waiver does not adversely affect the health and safety of patients. This STANDARD is not met as evidenced by: Based on observation during the survey walk-through, staff interview, and document review during the life safety code portion of a recertification survey conducted on February 22, 2016 the surveyor finds that the facility does not comply with the applicable provisions of the 2000 Edition of the NFPA 101 Life Safety Code.	C 231			

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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
C 231	Continued From page 2	C 231			
C 279	See the Life Safety Code deficiencies identified with associated K-Tags. 485.635(a)(3)(vii) PATIENT CARE POLICIES [The policies include the following:] Procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the practitioner responsible for the care of the patients, and that the requirement of §483.25(i) of this chapter is met with respect to inpatients receiving posthospital SNF care. This STANDARD is not met as evidenced by: Based on a review of Critical Access Hospital (CAH) policy, observation, and staff interview, it was determined that the CAH failed to ensure proper food storage as per policy. This has the potential to affect all patient/ staff utilizing dietary servicers at the CAH. Findings include: 1. The Hospital policy titled "Open Food Storage and Expiration of Food" was reviewed on 2/25/16. It indicated under "Policy: 3. As items are opened, they will be labeled with the date opened, and the use-by date". 2. During a tour of the CAH, conducted on 2/25/16 at 10:00 AM, the following items were observed without dates in Walk-In Freezer #1: two large bags of french fries, one large block of cheese (no name). 3. During the tour with the Dietary Manager (E # 12), E #12 verbalized that the foods should be	C 279			

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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	
C 279	Continued From page 3 identified and dated per policy. B. Based on a review of CAH policy, a review of Kitchen Refrigerator/Freezer Temperature Logs, and staff interview, it was determined that the CAH failed to ensure that deviations in Refrigerator/Freezer temperatures were followed up as per policy. This has the potential to affect all patient/ staff utilizing dietary servicers at the CAH. 1. The CAH policy titled "Nutritional Service Monitoring of Food-Containing Refrigerator and Freezer Temperatures" was reviewed on 2/25/16. It indicated under "Policy: "The Nutritional Service Department will monitor all assigned food containing refrigerator and freezer temperatures twice daily to maintain food safety guidelines". 2. The "Kitchen Refrigerator/Freezer Temperature Logs" that include "Upright freezer 1, Upright freezer 2, Chicken freezer, ice freezer, cook fridge, produce refrigerator, bread freezer and milk cooler" for February 2016 was reviewed on 2/25/16. There were no temperatures documented on 2/24/16 per policy. 3. During a staff interview conducted with the E #12 on 2/25/16 at 10:45 AM, E #12 stated, "The staff are expected to check refrigerators and document completion daily." C. Based on a review of CAH policy, a review of Kitchen Upright cooler, and staff interview, the CAH failed to ensure that all expired food items were removed from the kitchen cooler as per policy. This has the potential to affect all patient/ staff utilizing dietary servicers at the CAH.	C 279			

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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
C 279	Continued From page 4 1. The Hospital policy titled: "Open Food Storage" was reviewed on 2/25/16. It indicated under " policy: 3. As items are opened, they will be labeled with date opened, and use by date. 2. A tour of the CAH was conducted on 2/25/16 at 10:00 AM. The following items were observed in the Upright freezer 1: 2 cups of chopped up bacon in a large plastic bag dated expired 2/22/16, and a small round container of salad dressing (unidentified) with the expiration date of 2/24/16. 3. During a staff interview conducted with the E #12 on 2/25/16 at 10:45 AM, E #12 stated, "The staff are expected to check refrigerators and discard expired food per policy."	C 279			
C 294	485.635(d), (d)(1) NURSING SERVICES §485.635(d) Standard: Nursing Services Nursing services must meet the needs of patients. (1) A registered nurse must provide (or assign to other personnel) the nursing care of each patient, including patients at a SNF level of care in a swing-bed CAH. The care must be provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available. This STANDARD is not met as evidenced by: A. Based on document review and interview, it was determined in 1 of 20 (Pt #19) medical record reviewed, the CAH failed to ensure the nursing staff provided care to meet the patient needs as per policy. This has the potential to	C 294			

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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	
C 294	Continued From page 5 affect all patients receiving care at the CAH. Findings include: 1. The policy titled "Wound Care Protocol" (effective 06/2005) was reviewed on 2/25/2016 at approximately 2:00 PM. The policy indicated "To promote the continuity of quality of care, the Medical/Surgical floor will utilize the Wound Care Protocol of Quad County Home Health Procedure: - obtain an order to follow wound care protocol - Copy pertinent care plan provided by Derma Services - Treat wound per protocol - Chart as appropriate including the following information as needed: size of wound, color of wound, odor (if present), and any discomfort felt by the patient. 2. The clinical record of Pt #19 was reviewed on 2/25/2016 at approximately 11:00 AM. Pt #19 was admitted with a diagnosis of pneumonia and pressure ulcers. The clinical record did not have an order for the treatment of Pt #19's wounds. 3. An interview was conducted on 2/25/2016 at approximately 2:00 PM with the Inpatient Manager (E #3). E #3 agreed the policy was not followed by nursing staff..	C 294			
C 307	485.638(a)(4)(iv) RECORDS SYSTEMS [For each patient receiving health care services, the CAH maintains a record that includes, as applicable-] dated signatures of the doctor of medicine or	C 307			

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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	
C 307	Continued From page 6 osteopathy or other health care professional. This STANDARD is not met as evidenced by: Based on document review and staff interview, it was determined in 1 of 20 (Pt #1) medical record reviewed, the CAH failed to ensure verbal consent was authenticated by two staff members and circumstances requiring verbal consent was indicated as per policy. This has the potential to affect all patients receiving care at the CAH. Findings include. 1. The policy titled "Policies-General" (effective 4/15) was reviewed on 2/25/2016 at approximately 1:00 PM. The policy indicated under " E. Consent for Treatment and Procedure C. 2 .c. Telephonic: This is valid provided two persons listen in on the line. Each should record the time and circumstances on the ED cobra form." 2. The medical record of Pt #1 was reviewed on 2/22/2016 at approximately 10:00 AM. Pt #1 was seen in the emergency room on 2/21/2016 with a diagnosis of shortness of breath. The Emergency Treatment Consent indicated a telephone consent was obtained by one registered nurse and did not indicate the circumstances requiring a verbal consent. 3. An interview was conducted with Nurse Manager (E #3) on 2/22/2016 at approximately 1:00 PM. E #3 confirmed the verbal Emergency Treatment for Consent was not signed, dated or timed by two hospital staff members or indicate the circumstances, as hospital policy required.	C 307			

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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	
C 340	485.641(b)(4) QUALITY ASSURANCE [The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that--] (4) The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the CAH are evaluated by-- (i) One hospital that is a member of the network, when applicable; (ii) One QIO or equivalent entity; (i) One other appropriate and qualified entity identified in the State rural health care plan; (ii) In the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patients under a written agreement between the CAH and a distant-site hospital, the distant-site hospital; or (v) In the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patients under a written agreement between the CAH and a distant-site telemedicine entity, one of the entities listed in paragraphs (b) (4)(i) through (iii) of this section; and This STANDARD is not met as evidenced by: Based on internal documentation and staff interview, it was determined that the CAH failed to ensure it's Quality Assurance program included a program review by an outside review organization to determine that the Medical Staff provided quality treatment and appropriate diagnoses to the patients served by the Critical Access Hospital. This has the potential to affect all	C 340			

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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	
C 340	Continued From page 8 patients receiving care at the CAH. Findings include: 1. During an interview conducted with the Chief Nursing Officer (E #1) on 2/25/2016 at 2:45 PM, E #1 reported the medical staff conducts their own peer review unless indicated, the case will be sent out to External Peer Review Network for review. The medical staff only will send out a case if beyond their scope of practice or a conflict of interest. "I cannot recall the last time a case was sent out for review." E #1 reported that Telemedicine is peer reviewed on a quarterly basis by Clinical Radiology thru RADPEER, which is an external peer review organization.	C 340			

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - REHABILITATION AND WELLNESS CENTER B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 000	INITIAL COMMENTS On February 22, 2016 the life safety code portion of a Sample Validation Survey was conducted. The surveyors were accompanied during the survey walk-through by the following staff: Facility Director - F.D. President and Chief Executive Officer - C.E.O. The Rehabilitation and Wellness Center is a separate building on the Hospital campus. It is a single story slab on grade non sprinklered building of construction type II (000). The building was surveyed under the 2000 edition of the NFPA 101 Life Safety Code, chapter 39 Existing Business Occupancy. No deficiencies were found during the survey walk-through, staff interview, or document review, therefore, the requirements of 42 CFR Subpart 485.623, Physical Plant and Environment is met.	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

02/22/2016

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.

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - REHABILITATION AND WELLNESS CENTER B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 000	INITIAL COMMENTS On February 22, 2016 the life safety code portion of a Sample Validation Survey was conducted. The surveyors were accompanied during the survey walk-through by the following staff: Facility Director - F.D. President and Chief Executive Officer - C.E.O. The Rehabilitation and Wellness Center is a separate building on the Hospital campus. It is a single story slab on grade non sprinklered building of construction type II (000). The building was surveyed under the 2000 edition of the NFPA 101 Life Safety Code, chapter 39 Existing Business Occupancy. No deficiencies were found during the survey walk-through, staff interview, or document review, therefore, the requirements of 42 CFR Subpart 485.623, Physical Plant and Environment is met.	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

02/22/2016

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.

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 000	Continued From page 1 specific NFPA code and year of issue (such as NFPA 70 1999) are taken from the 2000 Edition of the NFPA 101 Life Safety Code. Unless otherwise noted, all deficiencies cited herein were found through observation during the survey walk-through, staff interview, or document review. The requirements of 42 CFR Subpart 485.623, Physical Environment, are NOT MET as evidenced by the deficiencies cited under the following K-Tags.	K 000	The Hospital submits the following AMENDED plan of correction ("POC") or report of correction for each deficiency. In addition, the Hospital submits an Interim Life Safety Measure ("ILSM") for each applicable deficiency, which it will implement until it completes the correction for the deficiency. The completion dates for some of the POCs go beyond the Medicare termination date of June 27, 2016. The Hospital requests CMS to extend the termination date to the latest completion date in the POCs.		
K 012	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation the facility failed to provide components of a building's designated construction type. This condition could affect individuals on the floor of fire incident from safely traveling the means of egress to the nearest exit stair and to a discharge on another floor. Finding include: On 02/22/2016 at 10:00 am, 3rd floor Center stair, the surveyor observed while accompanied by the facility F.D. and C.E.O., portions of the hospital which contain unprotected structural steel beams. This does not comply with the minimum construction type requirements of 19.1.6.2 and NFPA 220, 1999 Edition.	K 012	K 012 The Hospital will conduct an architectural survey of the buildings and determine their existing construction types, as the POCs for cited deficiencies depend on each building's construction type. The Hospital will complete the survey of the buildings, determine their construction types, and submit to IDPH an updated POC on how it will correct the building-type deficiencies. ILSM: Until the Hospital corrects the deficiencies, the Hospital's Director of Maintenance or his or her designee will increase the frequency of fire drills to two drills per quarter per shift and in-service staff again on the Hospital's RACER policy. Completion of the corrections will correct the cited deficiencies. To prevent recurrence of the deficiencies, the Director of Maintenance or his or her designee will conduct inspections quarterly of the ceiling systems to assure that they maintain their fire rating.		June 1, 2016
K 020	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings	K 020			

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 020	Continued From page 2 between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observations the facility failed to maintain properly rated shaft enclosures. This deficient practice could affect patients, staff and visitor if smoke and fire were allowed to expand from other areas of the facility through deficient shaft enclosures. Findings include: On 02/22/2016 at 10:15am, the surveyor, while accompanied by the C.E.O. and F.D. observed an access panel located in a 2-hour fire rated shaft. The framed-in opening did not contain a fire resistant rating. This condition does not comply with 18.3.1 and 8.2.5.2 for a continuous fire rated protected enclosure of the shaft wall. Location observed: 3rd floor surgery waiting room closet.	K 020	K 012 continued: The Facility Director or his or her designee will be responsible for monitoring the corrections so that the Hospital continues to comply with LSC requirements. K 020 As part of its POC for previous deficiencies, the Hospital reduced all vertical shafts to two floors. Reducing the vertical shafts corrected the cited deficiency. K 021 The Hospital hired an architect to prepare a scaled drawing of a Life Safety Floor Plan for the Basement Suite. See Attachment A that follows this page. The kitchen within the Basement Suite is not a hazardous area. The Life Safety Floor Plan shows the square footage of the Basement Suite and that the travel distances and intermediate rooms comply with Section 19.2.5.1 of the LSC. As a suite, the LSC does not require the door between the kitchen and the corridor to remain closed or to be self- closing. Therefore, the current door configuration complies with the LSC.	March 22, 2016 May 12, 2016	
K 021	NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed	K 021			

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 021	Continued From page 3 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. This STANDARD is not met as evidenced by: By direct observation/staff interview the surveyor finds the facility failed to install a means to automatically close the fire shutter separating the kitchen from the corridor. This deficient practice could result in the failure / response during a fire event, which may affect patients, staff and visitors. On 2/22/16 at 2:30PM in the company of the Chief Executive Officer, the surveyor finds that the fire shutter was being held open by a fusible link only and would not released to close by manual fire alarm operation or local smoke detection to comply with NFPA 72 1999 edition 2-10.6.	K 021			
K 029	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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 smoke resisting partitions 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 This STANDARD is not met as evidenced by:	K 029	K 029A: The Hospital removed the equipment and material from the room. See K 029 A – Attachment 1. K 029B: The Hospital will install a 45- minute rated, self-closing door in the space, which will separate the suite from the other space in accordance with the LSC. K 029C: The Hospital removed the equipment and linens from the alcove. See K 029 C – Attachment 1.		April 8, 2016 June 8, 2016 April 1, 2016

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 4 Based on observation the facility failed to provide complete separation between hazardous areas and the remainder of the building. These deficiencies could affect all patients within the smoke compartment, as well as any staff and visitors present, by allowing smoke and fire to escape from hazardous rooms into the exit access in the event of a fire condition. Findings include: A. On 02/22/2016 at 1:15 pm, 2nd floor, while accompanied by the F.D. and C.E.O, the surveyor observed a storage room (formerly patient room which is located across from the nurse station) which contains equipment and combustible materials that does not comply with 19.3.2.1 (7) and 8.4.1.3 for an adequate separation provided by a fire resistant self closing door and frame. The room lacks a 1-hour fire resistant enclosure to be shown on the facility life safety floor plans. B. On 02/22/2016 at 2:30 pm, Basement, while accompanied by the F.D. and C.E.O., the surveyor observed clean storage, material management, laundry room all connected with ceiling areas open to each other. C. On 02/22/2016 at 2:00 pm, 1st floor Emergency Department, while accompanied by the F.D. and the C.E.O., the surveyor observed equipment and linens stored in a corridor alcove. The amount of combustibles deems it a hazardous area which is not separated from a means of egress corridor. D. On 02/22/2016 at 2:10am, 1st floor Pharmacy room, while accompanied by the F.D. and the	K 029	K 029D: The Hospital hired an architect to prepare a scaled drawing of a Life Safety Floor Plan for the Medical Office Suite. See <i>Attachment B</i> that follows this page. Therefore, the current door configuration complies with the LSC. The Hospital assured that the Medical Office Suite contains no hazardous materials. One room contains free-standing file cabinets, which hold a limited number of medical records, but those cabinets and records are normal to the occupancy of the room. Assuring that the Medical Office Suite is not a hazardous area corrected the deficiency. ILSM: Until the Hospital corrects the deficiencies, the Hospital's Director of Maintenance or his or her designee will increase the frequency of fire drills to two drills per quarter per shift, in-service staff again on the Hospital's RACER policy, and document. Completion of the corrections will correct the cited deficiencies. To prevent recurrence of the deficiencies, the Director of Maintenance or his or her designee will inspect rooms monthly to assure that they remain free of improper storage of equipment and materials and that the doors maintain their necessary fire rating. The Facility Director or his or her designee will be responsible for monitoring the corrections so that the Hospital continues to comply with LSC requirements.	May 12, 2016	

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____	(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557	
(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 C.E.O., the surveyor observed a designated hazardous area (due to the amount of storage) which is sprinkler protected located adjacent to an office space, the office space does not comply with 8.4.1.3 due to the following: 1. The room did not appear to be sprinkler protected. 2. The room did not appear to have a fire rated separation from the pharmacy due to the lack of a fire rated door and frame.	K 029		
K 034	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4 This STANDARD is not met as evidenced by: Based on observation the facility failed to provide exit stairs constructed to provide a safe means of egress to a discharge. These deficiencies could affect any patients, staff, or visitors in the stair during a building or floor evacuation. Findings include: On 02/22/2016 at 10:00 am while accompanied by the F.D. and C.E.O., the surveyor observed stair landings which lack a continuous toe plate which are to prevent a person from tripping over the edge of a stair landing during vertical egress. The current condition does not comply with subpart (3) to 7.2.2.4.6. Example location observed, the "center" stair leading to the mechanical penthouse.	K 034	K 034 The Hospital will install a barrier at the landing level edges of the stairs to prevent an occupant from sliding under the existing barriers. Completion of the work corrected the deficiencies. To prevent recurrence of the cited deficiency, the Hospital's Director of Maintenance or his or her designee will conduct inspections quarterly of the landing barriers to assure that they remain in good repair. The Facility Director or his or her designee will be responsible for monitoring the corrections so that the Hospital continues to comply with LSC requirements.	June 21, 2016
K 046	NFPA 101 LIFE SAFETY CODE STANDARD	K 046	K 046 The Hospital tested the lighting and found that it operated properly. However, it also found that the lighting needed new batteries. The Hospital added testing of the emergency lighting to its PM schedule.	April 29, 2016

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 046	Continued From page 6 Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1. This STANDARD is not met as evidenced by: Based on document review the facility does not maintain proper records of required testing. This could effect anybody having surgery if the battery lights did not work upon loss of power. Findings include: On 2/22/16 at 2:45 pm, the surveyor observed during document review, while accompanied by the CEO and the FD, that records were not available showing that battery lights were tested for 30 seconds each month and for 90 minutes annually in accordance with the 2000 Edition of NFPA-101, Section 7.9.3.	K 046	The testing will comply with the requirements of the LSC. Because the cost of new batteries was the same as for new lights, the Hospital ordered new lights. When the new lights arrive, the Hospital will replace the current ones. Completion of the testing corrected the deficiencies. To prevent recurrence of the cited deficiency, the Hospital's Director of Maintenance or his or her designee will test emergency lighting in accordance with the PM schedule. The Facility Director or his or her designee will be responsible for monitoring the corrections so that the Hospital continues to comply with LSC requirements.		
K 047	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: Based on observation the facility failed to provide exit signs that are fully visible, or incorrectly identify paths of egress. This deficiency may affect all patients within the areas of the facility, as well as any staff and visitors present, by preventing those occupants from readily utilizing an available exit during a fire or smoke event. Findings include:	K 047	K 047, 1: The Hospital installed additional exit signage in the basement to identify the second means of egress. See <i>K 047 1 – Attachment 1</i> . K 047, 2: The Hospital installed additional exit signage in the exit path leading to the Center stairs. See <i>K 047 2 – Attachment 1</i> . Completion of the work corrected the deficiencies. To prevent recurrence of the cited deficiency, the Hospital's Director of Maintenance or his or her designee will conduct inspections monthly of exit signage to assure that they remain in good repair. The Facility Director or his or her designee will be responsible for monitoring the corrections so that the Hospital continues to comply with LSC requirements.	April 8, 2016 April 8, 2016	

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 047	Continued From page 7 On 2/22/2016 at 2:45 pm, surveyor observed, while accompanied by the facility F.D. and C.E.O., basement level exit signs are not provided to identify the 2nd means of egress to comply with 19.2.5.9, 19.2.5.10 and 7.10. Locations noted include the following: 1. Meeting room exit signage not clearly visible. 2. Exit path leading to Center stair not clearly visible.	K 047			
K 051	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6	K 051	K 051 The Hospital placed the necessary labels on the circuit panels. The labels indicate the circuit panel locations and overload positions. See <i>K 051 – Attachment 1</i> and <i>K 051 – Attachment 2</i> . Completion of the work corrected the deficiencies. To prevent recurrence of the cited deficiency, the Hospital's Director of Maintenance or his or her designee will inspect the panels quarterly to assure that they have the necessary labels. The Facility Director or his or her designee will be responsible for monitoring the corrections so that the Hospital continues to comply with LSC requirements.		April 8, 2016

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 051	Continued From page 8 This STANDARD is not met as evidenced by: Based on observation, the fire alarm panels are not properly labeled. This could effect facility maintenance staff if power is lost to the system. Findings include: On 2/22/16 at 9:30 am, while accompanied by the CEO and the FD, the surveyor observed the fire alarm panels located in the lower level conference room and the elevator lobby were not labeled with the life safety panel and circuit serving them in accordance with the 1999 Edition of NFPA-72, Section 1-5.2.5.2.	K 051			
K 067	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide a completely enclosed ventilation system. This deficient practice could result in the failure / response during a fire event, which may affect patients, staff and visitors. Finding includes: On 02/22/2016 at 10:30am, 2nd floor, while accompanied by the facility F.D. and C.E.O., the surveyor observed a duct penetration through the fire rated smoke barrier which was not installed as required by the duct/damper manufacturer. Location observed above the ceiling at the pair of cross corridor doors leading into surgery. This installation does not comply with 19.3.7.3 exception no. 2 and NFPA 90A .	K 067	K 067 The Hospital will correct the installation of the smoke barrier by installing sprinkler protection as provided in LSC 19.3.7.3. When the Hospital has full sprinkler protection, the Hospital will no longer require the smoke dampers, as section 19.3.7.3 of the LSC sets forth. At that time, the Hospital will decommission dampers on a zone-by-zone basis. Milestones for the sprinkler installation follow. * Award of Design Contract: June 15, 2016 * Design and IDPH Submission: September 1 2016 * Bidding and Award: December 1, 2016 * Installation and Commissioning: May 15, 2018 * IDPH Acceptance: June 1, 2018 Completion of the work corrected the deficiency. To prevent recurrence of the cited deficiency, the Hospital's Director of Maintenance or his or her designee will inspect all smoke barriers and firewalls as part of the environment of care rounds and normal preventive maintenance. The Director of Maintenance will correct any deficiencies he or she identifies. The Facility Director or his or her designee will be responsible for monitoring the corrections so that the Hospital continues to comply with LSC requirements.	June 1, 2018	

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 077	NFPA 101 LIFE SAFETY CODE STANDARD Piped in medical gas systems comply with NFPA 99, Chapter 4. This STANDARD is not met as evidenced by: By direct observation, the facility failed to correctly install / maintain the piped medical gas system. This deficient practice could result in the response during a fire event, which may affect patients, staff and visitors. A. On 2/22/16 at 11:00AM in the company of the Chief Executive Officer, the surveyor finds the medical gas zone valves serving the 1913 second floor patient room rooms are installed behind a normally open cross corridor door hidden from plain view in noncompliance with NFPA 99, 1999 4-3.1.2.3 (i). B. On 2/22/16 at 10:00AM in the company of the Chief Executive Officer, the surveyor finds the facility medical gas zone valves identification serving the 2nd and 3rd floor rooms outlets/inlets have not been updated to reflect renovation changes and the abandonment of outlets/inlets. NFPA 99, 1999, 4-3.1.2.14 (b) 3	K 077	K 077A: The Hospital will relocate the medical gas zone valves to a location that is both visible and accessible. Upon completion of the work and before Hospital staff uses the valves, the Hospital will recertify the valves, document the certification, and maintain the documentation onsite. See <i>K 077 A – Attachment 1</i>. K 077B: The Hospital updated the identification of the gas valves to reflect renovation changes and the abandonment of outlets and inlets. See <i>K 077 B – Attachment 1</i>. Completion of the work will correct the deficiency. To prevent recurrence of the cited deficiency, the Hospital's Director of Maintenance or his or her designee will inspect gas valves quarterly to assure that they have proper labels. The Facility Director or his or her designee will be responsible for monitoring the corrections so that the Hospital continues to comply with LSC requirements.	July 1, 2016	April 8, 2016
K 106	NFPA 101 LIFE SAFETY CODE STANDARD Hospitals and inpatient hospices with life support equipment have an Type I Essential Electric System, and nursing homes have a Type II ESS that are powered by a generator with a transfer switch and separate power supply in accordance with NFPA 99. 12-3.3.2, 13-3.3.2.1, 16-3.3.2 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation, the facility failed to to maintain a proper emergency power system. If the generator fails to operate upon the loss of normal power, this could effect all occupants of the building.	K 106	K106A, 1: The Hospital will replace this generator and install a remote panel as part of its upcoming project. Milestones for replacement of the generator and installation of the remote panel follow. * Award of Design Contract: June 15, 2016 * Design and IDPH submission: September 1, 2016 * Bidding and Award: November 1, 2016 * Installation and Commissioning: June 15, 2017	August 31, 2017	

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 106	Continued From page 10 Findings Include: A. On 2/22/16 at 11:00 am, while accompanied by the CEO and the FD, the surveyor observed that the generator annunciators were either missing or deficient. 1. The Onan generator was not equipped with a remote annunciator. 2. The Detroit generator annunciator did not meet the requirements of the 1999 Edition of NFPA-99, Section 3-4.1.1.15, and the 1999 Edition of NFPA-110, Table 3-5.5.2(d). B. On 2/22/16 at 2:00 pm, while accompanied by the CEO and the FD, the surveyor observed the batteries serving the generators were in unheated enclosures and were not equipped with battery heaters to meet the requirements of the 1999 Edition of NFPA-110, Section 3-3.1. C. On 2/22/16 at 2:00 pm, while accompanied by the CEO and the FD, the surveyor observed the battery charger for the batteries of the Onan generator was not connected in accordance with the requirements of the 1999 Edition of NFPA-110, Section 5-12.6.	K 106	K 012 continued: * IDPH Acceptance: August 31, 2017 Completion of the work will correct the deficiency. To prevent recurrence of the cited deficiency, Hospital staff will monitor the generator at a constantly attended location and address any abnormal condition it detects. ILSM: The Hospital will install a closed circuit TV monitor on the control panel of the generator so that Hospital staff can monitor the generator and detect any abnormal condition. The Hospital will train the staff on how to address an abnormal condition. K106A, 2: The Hospital will add a high engine-temperature monitor to the annunciator on the Detroit generator. K106B: The Hospital will install battery heaters. K106C: The Hospital will repair the battery charger for the Onan generator. Completion of the work will correct the deficiency. To prevent recurrence of the cited deficiency, the Hospital engineer will be responsible for testing all annunciator functions as part of the PM to assure continued compliance. The Facility Director or his or her designee will be responsible for monitoring the corrections so that the Hospital continues to comply with LSC requirements.	July 1, 2016 June 8, 2016 June 8, 2016	
K 130	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: A. Due to the number, variety, and severity of the life safety code deficiencies observed during the survey walk-through, the provider shall institute appropriate interim life safety measures until all cited deficiencies are corrected. The provider shall include, as an attachment to its	K 130	K 130 K130A: Necessary interim life safety measures ("ILSMs") for particular deficiencies are set forth in each of the	Ongoing until completion of corrections	

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 130	Continued From page 11 Plan of Correction (PoC) and referenced therein, a detailed narrative and proposed schedule for all such measures. The narrative shall describe all measures to be implemented, as well as the frequency with which they are to be conducted, and shall indicate the manner in which the measures are to be documented. The narrative shall also include comments related to changes in the interim life safety measures to remain in place as work toward the completion of its PoC progresses. B. On 02/22/2016 at 12:45 pm, 1st floor negative pressure patient room ante room, the surveyor observed while accompanied by the F.D. and C.E.O., a faucet mounted temperature pressure regulator installed over a sink which does not comply with ANSI Z358.1-1998.	K 130	POCs for those deficiencies. K130B: The Hospital will remove the existing eyewash and install an independent eyewash that complies with ANSI standards. See <i>K 130B – Attachment 1</i> . ILSM: The Hospital will continue to monitor and test the eyewash station and make adjustments, as needed. Completion of the work will correct the deficiencies. To prevent recurrence of the cited deficiency, the Hospital's Director of Maintenance or his or her designee will continue to monitor the eyewash station and provide training to staff on its proper use. The Facility Director or his or her designee will be responsible for monitoring the corrections so that the Hospital continues to comply with LSC requirements.		June 20, 2016
K 145	NFPA 101 LIFE SAFETY CODE STANDARD The Type I EES is divided into the critical branch, life safety branch and the emergency system and Type II EES is divided into the emergency and critical systems in accordance with 3-4.2.2.2, 3-5.2.2 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation, the emergency power was not properly divided into three branches. This could effect all occupants of the building if the emergency power failed to operate properly upon loss of normal power. Findings include: On 2/22/16 at 10:45 am, while accompanied by the CEO and the FD, the surveyor observed that all panels serving the second floor were served from one of the two emergency generators and all	K 145	K 145 The Hospital will hire a licensed electrical contractor to separate the Hospital's electrical circuits into life safety, critical, and equipment branches by May 15, 2016. The contractor will check all circuits to determine the extent of the circuit sharing. After the contractor checks the system, the contractor will prepare a one-line drawing, indicating a proposed plan to separate the electrical branches. The Hospital will submit the plan to IDPH for its approval by September 1, 2016. Within 10 days after the Hospital receives IDPH's approval for the completed plan, the Hospital will develop a schedule, with benchmarks, to indicate the circuit		June 17, 2016

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 145	Continued From page 12 panels were serving a mix of life safety, critical and equipment loads. This was not in compliance with the 1999 Edition of NFPA-70, Sections 517-30 through 517-35. Examples: 1. Panel EM2A serves a mix of critical and equipment loads. 2. Panel L3A serves a mix of critical and equipment loads. 3. Panel marked as Onan generator serves a mix of all branches of emergency power.	K 145	K 145 continued: modifications and new panel locations. It will submit the schedule to IDPH. At the same time, the contractor will begin to install new panels and feeders from the transfer switch to each of the appropriate branches, in accordance with the plan. In addition, the contractor will begin to move circuits to the appropriate distribution panels, in accordance with NFPA 99. Within 60 days of IDPH's approvals of the electrical plans, the electrical contractor will complete the electrical work in accordance with the approved plans.		
K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide a proper electrical system. This could effect any patient if a transfer switch failed. Findings include: A. On 2/22/16 at 10:00 am, while accompanied by the CEO and the FD, the surveyor observed the following areas were not equipped with normal power receptacles or receptacles served from two separate critical transfer switches as required by the 1999 Edition of NFPA-99, Section 3-3.2.1.2(a)1. 1. The operating rooms 2. The stage 1 recovery rooms 3. All patient rooms B. On 2/22/16 at 1:30 pm, while accompanied by	K 147	ILSM: Every day on each shift, the Director of Maintenance or his or her designee will take the temperature of each existing panel board, assure that they are not overheating, and verify that overload protections are operating properly. Completion of the work will correct the deficiencies. To prevent recurrence of the cited deficiency, the Hospital's Director of Maintenance or his or her designee will inspect the electrical wiring and assure that the wiring for emergency circuits is wired to the correct panels. The Facility Director or his or her designee will be responsible for monitoring the corrections so that the Hospital continues to comply with LSC requirements. K 147 K 147A: The Hospital will install a normal power receptacle in each Operating Room, Stage 1 recovery station, and patient room.		

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 147	Continued From page 13 the CEO and the FD, the surveyor observed that the elevator equipment room was not equipped with a lighting disconnect served from the life safety branch of emergency power in accordance with the 1999 Edition of NFPA-70, Section 620-22, and Section 517-32.	K 147	K 147 continued: ISLM: Once a week, the Hospital's Director of Maintenance or his or her designee will inspect the power receptacles. If he or she finds that any receptacle is not operating properly, he or she will notify appropriate and correct the problem. He or she will assure that temporary power is available, as needed.	August 20, 2016	
K 160	NFPA 101 LIFE SAFETY CODE STANDARD Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators & Escalators. All existing elevators, having a travel distance of 25 ft or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. 9.4.2, 9.4.3, 19.5.3 (Includes firefighters service phase I key recall and smoke detector automatic recall, firefighters service phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide an elevator recall system. This could effect anybody using the elevator during a fire. Findings include: On 2/22/16 at 2:30 pm, while accompanied by the CEO and the FD, the surveyor observed that the elevators were not equipped with a recall system to meet the requirements of ANSI/ASME A 17.1.	K 160	K 147B: The Hospital will install a lighting-disconnect service from the Life Safety branch in the Elevator Machine room. ILSM: Every day on each shift, the Director of Maintenance or his or her designee will monitor the operation of the elevator-cab lighting and address any improper operation. In addition, the engineer will give the elevator maintenance firm a sign that indicates the disconnect and overload location. Completion of the work will correct the deficiencies. To prevent recurrence of the cited deficiency, the Hospital's Director of Maintenance or his or her designee will check the operation of the elevator-cab lighting as part of the PM schedule. The Facility Director or his or her designee will be responsible for monitoring the corrections so that the Hospital continues to comply with LSC requirements. K160 The Hospital will award elevator mods to provide recall for all elevators with travel over 25 feet. Due to the age of the equipment, extensive controller modifications will be required. This will result in a need to a longer duration in the		

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 141341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - PANA COMMUNITY HOSPITAL B. WING _____		(X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER PANA COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 101 E NINTH STREET PANA, IL 62557		
(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 160 continued: completion date. The Hospital will upgrade the elevator so that it has a recall system. ILSM: The Hospital will continue to work with the local fire department in preplanning exercises and continue with ongoing in-services to reinforce how to relocate patients and visitors to adjacent compartments as well as vertical evacuation. Completion of the work will correct the deficiencies. To prevent recurrence of the cited deficiency, the Hospital's Director of Maintenance or his or her designee will inspect the elevator recall system quarterly to assure that it remains in good working order. The Facility Director or his or her designee will be responsible for monitoring the corrections so that the Hospital continues to comply with LSC requirements.		

Project Costs and Sources of Funds: Comparison to State Standards

Uses of Funds		State Standard		Project	Met Standard?
Preplanning Costs	\$5,901	1.80 %	\$151,686	0.07 %	Yes
Site Survey, Soil Investigation, and Site Preparation	\$132,995	5.00 %	\$421,350	1.58 %	Yes
New Construction Contracts and Contingencies	\$6,112,458	\$437.09/ GSF	\$5,672,116.93	\$471.02	No ¹
Modernization Contracts and Contingencies	\$678,193	\$305.96/ GSF	\$547,362	\$379.09	No ²
Contingencies	\$397,296	10 - 15 %	\$1,181,939	6.2 %	Yes
Architectural and Engineering Fees	\$648,940	7.40 - 11.12 %	\$876,211	10.2 %	Yes
Consulting and Other Fees	\$354,643	Not Applicable			
Movable or Other Equipment	\$428,240				
Net Interest Expense	\$65,630				

¹ Applicant understands that the costs of the new construction contracts and contingencies exceed State Standards. This is because of the complexities in connecting new construction to existing building construction. For example, the floor to ceiling heights in the existing 1955 building make it challenging and costly to make this connection, requiring the Hospital to use a more costly delta beam system instead of a regular system.

² Applicant understands that the costs of the modernization contracts and contingencies exceed State Standards. This is due to the age of the renovated areas, which have not been renovated in over 40 years. Also, the modernization includes upgrades to the Hospital's life safety systems, as part of its plan of correction to IDPH's last Life Safety Code survey, which adds significant costs. For example, the Hospital has to spray any exposed steel with fireproofing material.

Project Costs and Sources of Funds

Use Of Funds	Clinical	Non-Clinical	Total
Preplanning Costs	5,901	8,484	14,385
Site Survey and Soil Investigation	6,225	9,211	15,436
Site Preparation	126,770	187,571	314,341
Off Site Work			
New Construction Contracts	5,754,841	7,762,371	13,517,212
Modernization Contracts	638,514	1,430,600	2,069,114
Contingencies	397,296	571,269	968,565
Architecture/Engineering Fees	648,940	933,108	1,582,048
Consulting and Other Fees	354,643	509,939	864,582
Movable or Other Equipment (not in construction contracts)	428,240	412,339	840,579
Bond Issuance Expense (project related)			
Net Interest Expense During Construction (project related)	65,630	94,370	160,000
Fair Market Value of Leased Space or Equipment			
Other Costs To Be Capitalized			
Acquisition of Building or Other Property (excluding land)			
Total Uses of Funds	8,427,000	11,919,262	20,346,262
Source of Funds	Clinical	Non-Clinical	Total
Cash and Securities	4,906,476	6,939,786	11,846,262
Pledges			
Gifts and Bequests			
Bond Issues (project related)			
Mortgages	3,520,524	4,979,476	8,500,000
Leases (fair market value)			
Government Appropriations			
Grants			
Other Funds and Sources			
Total Sources of Funds	8,427,000	11,919,262	20,346,262

Modification Note: Applicant modified this attachment to remove the costs of site "improvements" from the site preparation costs, to add the DGSF of circulation space and necessary clinical support areas to the clinical space, and to adjust the costs of the clinical and non-clinical space to account for the addition of the DGSF to the clinical space.

Cost Space Requirements

Department/ Area	Cost	Gross Square Feet		Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Mod'n	As Is	Vacated Space
Reviewable (Clinical Space)							
Surgical Operating Suite	\$3,904,028	2,543	5,375	5,375	0	0	0
Post-Anesthesia Recovery Phase I	\$183,530	215	356	356	0	0	0
Post-Anesthesia Recovery Phase II	\$1,033,346	181	2,040	2,040	0	0	0
Laboratory	\$933,192	881	1,974	1,530	444	0	0
Mammography	\$138,426	158	268	268	0	0	0
Bone Density	\$80,576	90	156	156	0	0	0
Nuclear Medicine	\$329,103	238	451	301	150	0	0
Ultrasound	\$407,085	223	739	739	0	0	0
Cardiopulmonary	\$395,033	873	1,020	659	361	0	0
Urgent Care	\$605,274	0	1,368	1,368	0	0	0
Emergency	\$417,407	3,084	2,821	185	834	1802	0
Total Clinical	\$8,427,000	8,486	16,568	12,977	1,789	1,802	0
Non-reviewable (Non-clinical Space)							
Cafeteria	\$282,607	400	942	942	0	0	0
Kitchen	\$853,324	1,331	2,689	1,941	748	0	0
Materials Management	\$238,418	863	1,795	1,594	0	201	0
Patient Registration	\$419,899	445	2,179	700	1,479	0	0
Patient Financial Services	\$270,828	1,044	1,390	0	1,390	0	0
Health Information Management	\$79,118	371	862	0	400	462	0

Public/Waiting Areas	\$1,362,257	8,575	14,069	3,898	3,003	7,168	0
Staff Support Areas	\$818,600	6,077	8,762	1,436	1,306	6,020	0
Storage	\$332,442	2,000	4,670	1,428	1,069	2,173	0
Mechanical	\$701,130	2,170	6,012	3,842	0	2,170	0
Elevator/Stairs/HVAC System	\$477,312	1,979	4,379	2,400	0	1,979	0
Electrical/IT	\$211,239	582	1,602	1,020	0	582	0
Site Improvements/Const/Parking	\$2,057,024						
Core & Shell	\$3,815,066						
Total Non-Clinical	\$11,919,262	25,837	49,351	19,201	9,395	20,755	0
TOTAL SPACE	\$20,346,262	34,323	65,919	32,178	11,184	22,557	0

The type of gross square footage reported above is department/ area gross square footage (DGSF).

As part of this Project, when the new surgical suite receives licensure approval, the Hospital will convert certain space in the existing surgical suite and surgery waiting room to office space for the Patient Financial Services Department and the Medical Records/Health Information Management Department. The Hospital will convert the former Patient Financial Services Department offices and Medical Records/Health Information Management Department office to additional patient registration space, nursing office space, storage space, and public restrooms. Also as part of this Project, when the new Laboratory, Phlebotomy, and manager offices are completed, the Hospital will convert the existing Laboratory Office and Phlebotomy room to patient waiting area space.

Modification Note: Applicant modified this attachment to remove the costs of site "improvements" from the site preparation costs, to add the DGSF of circulation space and necessary clinical support areas to the clinical space, and to adjust the costs of the clinical and non-clinical space to account for the addition of the DGSF to the clinical space.

Size of the Project

The proposed amount of clinical space for the Project is 16,568 departmental gross square feet. Applicant's determination of square footage includes all necessary components of the clinical space.

The areas in the Hospital having identified standards in the Board's rules are the following: Surgical Operating Suite, Post-Anesthesia Recovery Phase I, Post-Anesthesia Recovery Phase II, Mammography, Bone Density, Nuclear Medicine, Ultrasound, Emergency Department, and Urgent Care. The amount of physical space for the Project is necessary and not excessive.

Department/Service	Proposed DGSF	State Standard (DGSF)	Difference (DGSF)	Met Standard?
Clinical				
Surgical Operating Suite (Class C)	5,375	2,750 DGSF/ Operating Room	-125	Yes
Post-Anesthesia Recovery Phase I ¹	356	180 DGSF/ Recovery Station	-4	Yes
Post-Anesthesia Recovery Phase II ²	2,040	400 DGSF/ Recovery Station	-360	Yes
Laboratory	1,974	N/A	N/A	N/A
Mammography	268	900 DGSF/Unit	-632	Yes
Bone Density ³	156	1,300 DGSF/Unit	-1,144	Yes
Nuclear Medicine	451	1,600 DGSF/Unit	-1,149	Yes
Ultrasound	739	900 DGSF/Unit	-161	Yes
Cardiopulmonary	1,020	N/A	N/A	N/A
Urgent Care ⁴	1,368	800 DGSF/ Room	-1,832	Yes
Emergency Department ⁵	2,821	900 DGSF/ Treatment Station	-1,866	Yes
Non Clinical				
Cafeteria	942	N/A	N/A	N/A
Kitchen	2,689	N/A	N/A	N/A
Materials Management	1,795	N/A	N/A	N/A
Patient Registration	2,179	N/A	N/A	N/A

¹ Post-Anesthesia Recovery Phase I will have two recovery stations.

² Post-Anesthesia Recovery Phase II will have six recovery stations.

³ Part of Fluoroscopy/ Tomography/ Other X-ray procedures, as defined in 77 Ill. Adm. Code 1100.220.

⁴ Urgent Care area will have 4 key rooms.

⁵ Emergency Department modifications will have three examination stations and two trauma stations.

Patient Financial Services	1,390	N/A	N/A	N/A
Health Information Management	862	N/A	N/A	N/A
Public/Waiting Areas	14,069	N/A	N/A	N/A
Staff Support Areas	8,762	N/A	N/A	N/A
Storage	4,670	N/A	N/A	N/A
Mechanical	6,012	N/A	N/A	N/A
Elevator/Stairs/HVAC System	4,379	N/A	N/A	N/A
Electrical/IT	1,602	N/A	N/A	N/A

Specifically to address 77 Ill. Adm. Code 1110.234(c), the proposed departmental gross square footage is necessary and appropriate for Cardiopulmonary, Laboratory, and Urgent Care. The Laboratory will provide 1,093 additional square feet of space, which will allow the Hospital to have more modern laboratory equipment and to connect to Phlebotomy. Cardiopulmonary will provide an additional 147 square feet of space, allow the Hospital to provide stress tests near nuclear imaging, and contain a Cardiopulmonary Lab for better care of patients. Urgent Care will reduce over-utilization of the Emergency Department.

Project Services Utilization

Dept./ Service	Historical Utilization/ Patient Days, etc. (2016)	Projected Utilization (2020)	State Standard	Met Standard?
Bone Density	120	190	6,500 procedures	Yes*
Nuclear Medicine	108	130	2000 visits	Yes*
Ultrasound	1,173	1,300	3100 visits	Yes*
Mammography	792	840	5000 visits	Yes*

Emergency ¹	7,879	5,396	2000 visits/station/year	No**
Urgent Care	N/A	2,031	2000 visits/year	Yes

* There will be only one room for these services. Utilization standards are applicable to justify having more than one room.

** Though the projected utilization in 2020 does not meet the State Standard, the Hospital's Emergency Department has historically had more than 8,000 visits per year (8,616 in 2013, 8,323 in 2014, and 8,647 in 2015). The Hospital projects a decrease in ER visits as patients begin to utilize the new Urgent Care Center. Until then, however, the Hospital will continue to need to maintain 5 stations in the Emergency Department.

Surgery Center Utilization					
	Dept./ Service	Historical Utilization/ Patient Days, etc. (2016)	Projected Utilization	State Standard	Met Standard?
Year 1 (2019)	Surgical Operating Suite (Class C)	1, 114 hrs	1,544 hrs	1,500 hrs/ Operating Room	Yes
Year 2 (2020)	Surgical Operating Suite (Class C)	1, 114 hrs	1,590 hrs	1,500 hrs/ Operating Room	Yes

The Hospital bases these projections on actual growth in the number of service hours it has provided in its surgical department over the last several years. The Hospital has made specific efforts to grow its Surgical Services by hiring a general surgeon in 2012 and contracting with an orthopedic surgeon in 2016. It expects the growth to continue, but at a reduced rate over time and eventually leveling out approximately two years after project completion. See the table below.

¹ Emergency Department will have 5 stations.

Year	Hours	Growth % over previous year	
2013	652		actual
2014	820	26%	actual
2015	871	6%	actual
2016	1,114	28%	actual
2017	1,337	20%	projected
2018	1,470	10%	projected
2019	1,544	5%	projected
2020	1,590	3%	projected

CSAs Other than Categories of Services

The Categories of Services that will be part of the modernization project are Diagnostic Imaging (excluding MRI, CT, and general radiology), Laboratory, Emergency Room services, Ambulatory Care Services and Nuclear Medicine.

Diagnostic Imaging includes bone density, mammography, and ultrasound. There will be one machine for each service. CT, general radiology, and MRI are not part of the modernization project.

HFSRB does not have standards for laboratories. Laboratory utilization is based on historical utilization. The proposed Laboratory will have one general lab room, one phlebotomy room, and one microbiology room.

In 2015, the Hospital provided the following:

- 8,647 Emergency Department Visits
- 6,692 General Radiography/ Fluoroscopy Procedures
- 669 Mammography Procedures
- 123 Nuclear Medicine Procedures
- 1182 Ultrasound Procedures

In 2016, the Hospital provided the following:

- 1,114 hours in the Surgical Operating Suite (Class C)
- 120 bone density cases
- 15,746 lab services

Diagnostic Imaging, the Laboratory, Surgery, and Nuclear Medicine will keep the same amount of rooms for these services. With the addition of an Urgent Care Center, the Hospital will provide Ambulatory Care Services, which will decrease the utilization of the emergency room for services more appropriately provided in urgent care. The Hospital will then be able to reduce the number of stations in the Emergency Department from six to five.

Urgent Care Center will have four key rooms, including three examination rooms and one triage room. The Hospital projects that Urgent Care will operate 30 hours per week and have approximately 1,300 visits in its first year of operation. The Hospital plans to have only one health care provider working in the Urgent Care Center.

Reasonableness of Financing Arrangement

A. Reasonableness of Financing Arrangements

See attached certifications.

B. Conditions of Debt Financing

See attached certifications.

C. Reasonableness of Project Costs

Cost and Gross Square Feet by Department or Service										
Department(list below)	A	B	C	D	E	F	G	H		
	Cost/Square Foot		Gross Sq. Ft.		Gross Sq. Ft.		Const.\$ (A x C)	Mod.\$ (B x E)	Total Cost (G + H)	
	New	Mod.	New	Circ	Mod.	Circ				
Surgical Operating Suite	693.26		5375	22%	0	0%	3,726,270	-	3,726,270	
Post-Anesthesia Recovery Phase I	491.52		356	53%	0	0%	174,979	-	174,979	
Post-Anesthesia Recovery Phase II	482.52		2040	44%	0	0%	984,350	-	984,350	
Laboratory	447.81	455	1530	0%	444	0%	685,151	202,020	887,171	
Mammography	490.94		268	0%	0	0%	131,573	-	131,573	
Bone Density	490.94		156	0%	0	0%	76,587	-	76,587	
Nuclear Medicine	690.27	700.00	301	0%	150	0%	207,770	105,000	312,770	
Ultrasound	523.73		739	0%	0	0%	387,039	-	387,039	
Cardiopulmonary	364.89	374.74	659	30%	361	0%	240,463	135,280	375,742	
Urgent Care	421.54		1368	28%	0	0%	576,668	-	576,668	
Emergency	380	391.19	185	10%	834	39%	70,300	326,254	396,554	
Cafeteria	286.03		942	35%	0	0%	269,436	-	269,436	
Kitchen	298.64	310.00	1941	0%	748	0%	579,669	231,880	811,549	
Materials Management	142.74		1594	0%	0	0%	227,522	-	227,522	
Patient Registration	179	185.45	700	0%	1479	0%	125,300	274,287	399,587	

Patient Financial Services		185.52	0	0%	1390	25%	-	257,872	257,872
Medical Records		188.47	0	0%	400	8%	-	75,390	75,390
Public/Waiting Areas	185.06	192	3898	86%	3003	56%	721,355	576,576	1,297,931
Staff Support Areas	285.00	293.86	1436	31%	1306	22%	409,260	383,780	793,040
Storage	120	136.17	1428	0%	1069	0%	171,360	145,565	316,925
Mechanical	173.79		3842	0%	0	0%	667,705	-	667,705
Elevator/Stairs/HVAC System	189.35		2400	76%	0	0%	454,445	-	454,445
Electrical/IT	197.15		1020	0%	0	0%	201,097	-	201,097
Core & Shell	112.57		32178	0%	0	0%	3,622,370	-	3,622,370
Site Improvements/ Const/ Parking	N/A	N/A	N/A	N/A	N/A	N/A	1,953,125	-	1,953,125
Contingency	N/A	N/A	N/A	N/A	N/A	N/A	718,751	249,814	968,565
TOTALS	7,647	3,412	32,178	4	11,184	2	17,382,545	2,963,717	20,346,262

D. Projected Operating Costs (2019)

Projected Operating Costs	Total Cost	Treatments	Cost/ Treatment
Personnel	3,898,467	11,012	354.02
Medical Supplies	615,666	11,012	55.91
Other Supplies	247,267	11,012	22.45
Medical Director Fees	-0-	11,012	-0-
Rent	-0-	11,012	-0-
Management Fee	-0-	11,012	-0-
Other	3,095,320	11,012	281.09
Total Projected Operating Costs	7,856,720	11,012	713.47

E. Total Effect of the Project on Capital Costs

	Total Cost	Treatments	Cost/ Treatment
Total Effect of the Project on Capital Costs	1,192,305	11,012	108.27