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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1ILJ

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00655

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245231**

2.STATE VENDOR OR MEDICAID NO.
(L2) **705040200**

3. NAME AND ADDRESS OF FACILITY
(L3) **APPLETON MUNICIPAL HOSPITAL**
(L4) **30 SOUTH BEHL STREET**
(L5) **APPLETON, MN** (L6) **56208**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/06/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

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

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

FISCAL YEAR ENDING DATE: (L35)
**09/30**

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:

**X** A. In Compliance With Program Requirements

Compliance Based On:

___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | **50** | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE — Date :
LoAnn DeGagne, HFE-NE II — 07/28/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Anne Peterson, Enforcement Specialist — 09/05/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
**08/01/1982**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**03001**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
**07/05/2017**
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
*of* Health

**PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS**

CMS Certification Number (CCN): 245231
July 28, 2017

Ms. Kathy Johnson, Administrator
Appleton Municipal Hospital
30 South Behl Street
Appleton, MN 56208

Dear Ms. Johnson:

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

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

Effective June 27, 2017 the above facility is certified for or recommended for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

cc: Licensing and Certification File

MDH
Minnesota
Department
*of* Health

**PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS**

Electronically delivered July 28, 2017

Ms. Kathy Johnson, Administrator
Appleton Municipal Hospital
30 South Behl Street
Appleton, MN 56208

RE: Project Number S5231027

Dear Ms. Johnson:

On June 2, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 18, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 6, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 27, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 18, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 27, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 18, 2017, effective June 27, 2017 and therefore remedies outlined in our letter to you dated June 2, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

cc: Licensing and Certification File

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL** — ID: 1ILJ

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY** — Facility ID: 00655

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2.STATE VENDOR OR MEDICAID NO.
(L2) **705040200**

3. NAME AND ADDRESS OF FACILITY
(L3) **APPLETON MUNICIPAL HOSPITAL**
(L4) **30 SOUTH BEHL STREET**
(L5) **APPLETON, MN** (L6) **56208**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/18/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
**09/30**

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 50 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE Date :
Christine Bodick-Nord, HFE NE II 06/12/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 07/03/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
**08/01/1982**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**03001**
(L31)

30. REMARKS
Posted 07/05/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
*of* Health

**PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS**

Electronically delivered
June 2, 2017

Ms. Kathy Johnson, Administrator
Appleton Municipal Hospital
30 South Behl Street
Appleton, MN 56208

RE: Project Number S5231027

Dear Ms. Johnson:

On May 18, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Kathy Lucas, Unit Supervisor
St. Cloud B Survey Team
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
kathy.lucas.state.mn.us
Telephone: (320)223-7343 Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 27, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 27, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

### Original deficiencies not corrected

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

### Original deficiencies not corrected and new deficiencies found during the revisit

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

### Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 18, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 18, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

## INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | C 05/18/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **APPLETON MUNICIPAL HOSPITAL** | **30 SOUTH BEHL STREET APPLETON, MN 56208** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>On 5/15-18/17, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 176 SS=D | 483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE<br><br>(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed ensure a resident was safe to self-administer medications for 1 of 1 resident (R34) reviewed for medication administration of a nebulizer medication.<br><br>Findings include: | F 176 | 1) Resident R34 will be assessed for self-administration of medications by 06/15/17<br>2) All residents will be assessed for self-administration of medications that are clinically appropriate by 06/15/17.<br>3) Policy and procedure will be reviewed and revised as appropriate. Staff | 6/27/17 |

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

Electronically Signed | 06/09/2017

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | C 05/18/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **APPLETON MUNICIPAL HOSPITAL** | **30 SOUTH BEHL STREET APPLETON, MN 56208** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 176 | Continued From page 1<br>R34's admission record dated 5/18/17, included a diagnoses of chronic obstructive pulmonary disease.<br><br>R34's physician orders dated 1/20/17, indicated an order for "DuoNeb Solution 0.5-2.5 (3) milligrams (mg)/3 milliliters (ml) with directions to inhale one vial three times a day.<br><br>During an observation on 5/17/17, at 10:19 a.m. trained medication aide (TMA)-A added the nebulizer medication to a nebulizer machine in R34's room and applied a mask to R34's face. TMA-A turned on the machine and the medication began infusing through the mask. TMA-A informed R34 she would return in fifteen minutes and left the room. Upon leaving R34's room, TMA-A was asked about the self administration of the nebulizer. TMA-A stated she believed R34 had an order for self-administration. TMA-A immediately reviewed R34's Medication Administration Record (MAR) and stated there was no order or direction for R34 to self-administer the nebulizer. While TMA-A was looking at the MAR, the assistant director of nursing (ADON) approached the medication cart. When asked if staff had assessed R34 to determine if R34 could safely self-administer the nebulizer medication, the ADON left to review R34's record. The ADON returned a few minutes later, stating R34 did not have an assessment completed to determine safe to self-administer the nebulizer medication. Approximately ten minutes after TMA-A started the nebulizer, R34 was observed to be sleeping in his chair. The mask was still on R34's face. The nebulizer machine was on. No staff were present in the resident's room. | F 176 | education will be conducted on 06/15/17 of any changes to policy and procedures.<br>4) Audits of random residents' orders will be conducted 2X/weekly for four weeks and then continue audit monthly. All new admissions will be assessed for appropriateness of self-administration of medications by IDT. Results to be reported to QA committee | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | C 05/18/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON MUNICIPAL HOSPITAL | 30 SOUTH BEHL STREET APPLETON, MN 56208 |

| (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 |
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| F 176 | Continued From page 2<br>The facility's undated policy titled Self-Administration of Medications, indicated the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medication is clinically appropriate for the resident. The staff and practitioner will document their findings and the choices of residents who are able to self-administer medications. | F 176 | | |
| F 242 SS=D | 483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES<br><br>(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure resident preferences with breakfast food were honored for 1 of 3 residents (R7) reviewed for nutrition.<br><br>Findings include:<br><br>R7's quarterly Minimum Data Set (MDS) dated 2/3/17, identified a moderate cognitive | F 242 | 1) R7 has received meal of choice since 05/18/17<br>2) Staff training on resident choice to be completed by 06/15/17<br>3) Policy and procedure will be reviewed and updated as appropriate by 06/15/17<br>4) Audits of resident choice at mealtimes will be completed 3 X/weekly for four weeks, then randomly weekly. Results to | 6/27/17 |

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| F 242 | Continued From page 3<br>impairment, independent after set up with eating, and noted a weight loss.<br><br>R7's Nutrition Assessment dated 4/18/16, indicated R7 did not like many of the foods served in the facility. The assessment further indicated breakfast was R7's favorite meal of day with food preferences of oatmeal, soft fried eggs, boiled eggs, and toast.<br><br>A facility menu dated 5/17/17, identified breakfast choices included sausage links, toast, hard boiled eggs, and cereal of choice.<br><br>During observation on 5/17/17, at 7:29 a.m. R7 was observed sitting at a dining room table. R7 motioned for assistance and the assistant director of nursing (ADON) came over to R7. R7 requested oatmeal for breakfast. The ADON stated there was no oatmeal and asked if R7 would like cream of wheat instead. R7 replied she did not like cream of wheat and wanted oatmeal. The ADON asked R7 if she would like a hard boiled egg instead. At 7:34 a.m. dietary aide (DA)-A brought R7 a plate containing a piece of toast cut in half, a hard boiled egg, and sausage links. R7 asked DA-A if there was any bacon today and DA-A indicated there was no bacon. DA-A assisted R7 with setting up her breakfast by cutting up her sausage links and egg before walking away. There were no additional dietary staff that came to take R7's order. R7 did not receive oatmeal for breakfast.<br><br>During interview on 5/17/17, at 8:19 a.m. DA-A stated R7 would eat pretty good in the mornings and always loved her bacon but would also do sausage links with her hard boiled eggs and toast. DA-A stated the facility rarely served | F 242 | be reported to QA committee. | |

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| F 242 | Continued From page 4<br>oatmeal because not a lot of residents liked oatmeal. DA-A reported the facility had no instant oatmeal packets to make for R7 and the kitchen would have to pre-make the oatmeal if R7 wanted some.<br><br>During interview on 5/17/17, at 12:21 p.m. the dietary manager (DM) stated R7 had lost some weight, needed encouragement with eating, would sometimes refuse to eat, and staff would offer her alternatives. The DM stated she assessed food preferences annually. The DM reported the "cereal of choice" meant there were always cold cereals available and the kitchen switched the hot cereal between cream of rice, cream of wheat, malt-o-meal, and oatmeal. The DM thought oatmeal was not made very often but was available for residents if they wanted it.<br><br>During interview on 5/18/17, at 9:25 a.m. the ADON stated he had been walking by when R7 asked about the oatmeal and typically the dietary aides would take breakfast orders for the residents. The ADON did not think the kitchen had instant packets of oatmeal and was not aware if oatmeal was available. The ADON further stated he should have found out if oatmeal was available and followed through because R7 had lost some weight and did not eat great at meals. The ADON stated R7 should get what she wants to eat and resident food preferences should be communicated across dietary and nursing staff.<br><br>A policy of resident preferences was requested but not received. | F 242 | | |
| F 282 SS=D | 483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN | F 282 | | 6/27/17 |

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| F 282 | Continued From page 5<br><br>(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(ii) Be provided by qualified persons in accordance with each resident's written plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure nutritional supplements were administered according to resident care plans for 1 of 3 residents (R7) reviewed for nutrition.<br><br>Findings include:<br><br>R7's quarterly Minimum Data Set (MDS), dated 2/3/17, identified a moderate cognitive impairment, was independent after set up with eating, was on a mechanically altered diet, and noted a weight loss.<br><br>R7's Diagnosis Report, dated 5/18/17, identified active diagnoses of dementia without behaviors, depression, and dysphagia (difficulty swallowing).<br><br>R7's physician's orders, dated 5/18/17, indicated she had been taking a house supplement twice a day since 11/10/16, and had been increased in frequency to three times a day on 4/15/17.<br><br>R7's initial care plan, dated 11/7/16, identified a nutritional problem related to weight loss needing a nutritional supplement and directed to administer supplements between meals. However, R7's care plan was revised, on 5/18/17, | F 282 | 1) R7s care plan reviewed and updated to reflect current choice.<br>2) All residents receiving supplements will be audited to ensure care plan reflects care given.<br>3) Staff education regarding supplements and appropriate care planning to be completed by 6/15/2017.<br>4) Audits of residents receiving supplements will be completed 3x each week for four weeks then weekly for four weeks then random audits monthly to ensure compliance of care plan. Results to be reported to QA committee. | |

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| F 282 | Continued From page 6<br>and directed to administer supplments "as ordered."<br><br>R7's electronic medication administration record (eMAR) was reviewed for 5/17. There was no documentation on the eMAR before 5/15/17, identifying that R7 was administered the house supplement, and lacked documentation of supplement intakes. However, after 5/15/17, R7's supplement was ordered at 9:00 a.m., 2:00 p.m., and 8:00 p.m.<br><br>During interview on 5/16/17, at 8:52 a.m. the director of nursing (DON) verified there was no documentation and tracking of supplements prior to 5/15/17, as the facility had switched over to an electronic medical record, and the supplement documentation "fell through the cracks."<br><br>During interview on 5/16/17, at 2:42 p.m. nursing assistant (NA)-B stated R7 had no appetite and thought she received a supplement at breakfast, but NA-B was not sure.<br><br>During interview on 5/17/17, at 10:55 a.m. trained medication aide (TMA)-A stated R7 was administered a four ounce supplement, three times a day, with meals. TMA-A reported she had given R7 the supplement around 8:00 a.m. with her breakfast that morning, showing on the eMAR R7 had drank 100% (percent) of the supplement. TMA-A stated R7 would be getting supplements with lunch and supper that day, reporting she was instructed to give them with meals because "that's just what we do with supplements."<br><br>During interview on 5/17/17, at 12:21 p.m. dietary manager (DM) stated nursing staff were responsible for administering the supplements | F 282 | | |

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| F 282 | Continued From page 7 | F 282 | | |

because they were suppose to be given outside the meals, separated so residents eat the meal not just the supplements. The DM stated the facility had been giving supplements with meals, however, the practice had been changed about a year prior.

During interview on 5/17/17 at 2:13 p.m. LPN-B stated R7's supplement order had been revised to show up on the eMAR so nursing staff could track her intakes. LPN-B verified R7's supplement was ordered for 9:00 a.m., 2:00 p.m., and 8:00 p.m., so would be given outside of the meals.

During observation on 5/18/17, at 8:57 a.m. R7 had finished eating breakfast, a glass containing her supplement was observed on the table by her meal. It was observed that R7 had been administered a supplement with her meal. DA-A stated R7 had drank about 50% of the supplement. During observation, the ADON stated every resident's care plan directed supplements to be given with meals.

During interview on 5/18/17, at 10:01 a.m. the DON stated supplements were administered according to the individual's care plan, and there were a few that wanted it with meals. The DON stated she encouraged staff to administer supplements in between meals so residents received the extra caloric intake. The DON stated she had not been aware of any problems with the supplement administration.

A facility policy entitled Nutrition (Impaired)/Unplanned Weight Loss- Clinical Protocol, revised 9/12, directed supplementation for increased nutrients and calories may include

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| F 282 | Continued From page 8<br>"providing between-meal snacks and/or nutritional supplementation." Staff were responsible for "Evaluating the care plan to determine if the interventions are being implemented and whether they are effective in attaining the established nutritional and weight goals." | F 282 | | |
| F 325 SS=D | 483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE<br><br>(g) Assisted nutrition and hydration.<br>(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure nutritional supplements were administered and monitored accurately for 1 of 3 residents (R7) reviewed for nutrition.<br><br>Findings include:<br><br>R7's quarterly Minimum Data Set (MDS) dated | F 325 | 1) Supplement monitoring added to clinical software program to be documented by TMA/Nurse.<br>2) All Residents receiving supplements have been added to clinical software program for monitoring.<br>3) Policy and procedure will be reviewed and updated by 6/15/17 to reflect practices for monitoring. Staff training on | 6/27/17 |

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| F 325 | Continued From page 9<br>2/3/17, identified a moderate cognitive impairment, was independent after set up with eating, was on a mechanically altered diet, and noted a weight loss.<br><br>R7's Diagnosis Report dated 5/18/17, identified active diagnoses of dementia without behaviors, depression, and dysphagia (difficulty swallowing).<br><br>R7's physician's orders dated 5/18/17, indicated she had been taking a house supplement twice a day since 11/10/16, and had been increased to a frequency of three times a day on 4/15/17.<br><br>R7's most recent dietary note dated 5/12/17, at 10:35 a.m. noted R7 had been having ongoing weight loss with a lower body mass index. Although the note indicated R7 had adequate meal intakes of 50-100%, it directed to encourage supplements to "assist w/weight [with weight] stability and gain."<br><br>R7's care plan dated 5/18/17, identified a nutritional problem related to weight loss needing a nutritional supplement. The care plan directed to administer supplements as ordered.<br><br>R7's electronic Medication Administration Record (eMAR) was reviewed for 5/17. There was no documentation on the EMAR before 5/15/17, identifying that R7 was administered the house supplement and lacked documentation of the amount of the supplement intakes.<br><br>During interview on 5/16/17, at 8:52 a.m. the director of nursing (DON) verified there was no documentation and tracking of supplements prior to 5/15/17, as the facility had switched over to an electronic medical record, and the supplement | F 325 | 6/15/17 on new policy and procedure.<br>4) Audit completion of monitoring of supplements 3X/weekly for four weeks. Random weekly auditing for four weeks, then monthly. Results to be reported to QA committee. | |

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| F 325 | Continued From page 10<br>documentation "fell through the cracks."<br><br>During interview on 5/16/17, at 2:42 p.m. nursing assistant (NA)-B stated R7 had no appetite and thought she received a supplement at breakfast, but NA-B was not sure.<br><br>During observation on 5/17/17, at 7:13 a.m. R7 was observed at breakfast. At 7:34 a.m. R7 received a plate with a piece of toast cut in half, hard boiled egg, and sausage links. In front of R7 was observed orange juice and coffee. R7 requested water and motioned to licensed practical nurse (LPN)-B who brought over a plastic glass of water. R7 was continuously observed during breakfast until 8:00 a.m. when the assistant director of nursing (ADON) assisted her back to her room. No supplement was administered during the breakfast observation.<br><br>During interview on 5/17/17, at 8:19 a.m. dietary aide (DA)-A was observed with a clip board recording intakes of meals and fluids. DA-A stated dietary staff were responsible for recording the intakes of residents' food and fluids, including supplements. DA-A reported R7 did not require a supplement and nothing was recorded at breakfast.<br><br>During interview on 5/17/17, at 8:37 a.m. NA-C stated she had given R7 supplements in the past, but had not observed R7 to receive supplements recently.<br><br>During interview on 5/17/17, at 10:55 a.m. trained medication aide (TMA)-A stated R7 was administered a four ounce supplement three times a day with meals. TMA-A reported she had given R7 the supplement around 8:00 a.m. with | F 325 | | |

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| F 325 | Continued From page 11 | F 325 | | |

her breakfast that morning, showing on the eMAR R7 had drank 100% (percent) of the supplement; however, during earlier continuous observation R7 did not receive a supplement. TMA-A further stated dietary filled regular plastic cups with supplements from the kitchen, then placed them on the juice cart to be passed out at meals. TMA-A reported supplements were documented on the eMAR by the nursing staff, but further reported dietary staff also recorded intakes so supplements were "taken care of twice." TMA-A stated R7 would be getting supplements with lunch and supper that day, reporting she was instructed to give them with meals because "that's just what we do with supplements."

During interview on 5/17/17, at 12:21 p.m. dietary manager (DM) stated nursing staff were responsible for administering the supplements because they were suppose to be given outside the meals, separated so residents eat the meal not just the supplements. The DM stated the facility had been giving supplements with meals, however, the practice had been changed about a year prior. The DM further stated nursing staff recorded the intakes of supplements on the eMAR, so it had to be nursing staff administering the supplements, not dietary. She further reported dietary was responsible for recording intakes of the food and fluids at meals, and R7's supplement was given by the TMA, not dietary.

During interview on 5/17/17 at 2:13 p.m. LPN-B stated R7's supplement order had been revised to show up on the eMAR so nursing could track her intakes. LPN-B reported prior dietary would come behind at meals and record the supplement with all R7's fluid intakes, not separately. LPN-B stated supplements were all pre-poured ahead of

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| F 325 | Continued From page 12 | F 325 | | |

time for meals and were kept on a cart, so either the TMA or dietary staff could administer them. LPN-B verified R7's supplement was ordered for 9:00 a.m., 2:00 p.m., and 8:00 p.m., so would be given outside of the meals.

During observation on 5/18/17, at 8:57 a.m. R7 had finished eating breakfast, a glass containing her supplement was observed on the table by her meal. DA-A was observed pouring the left over supplement into a glass with the rest of the fluids R7 had been served. DA-A then calculated the total percentage of fluids left over together. DA-A stated R7 had drank about 50% of the supplement. During observation, the ADON walked by, saw the empty supplement glass, and stated the TMA would chart R7 drank all of the supplement, however, was not aware all fluids had been poured together. The ADON further stated every residents care plan directed supplements to be given with meals.

During interview on 5/18/17, at 9:00 a.m. the registered dietician (RD) stated R7 was to be offered the supplements as tolerated. The RD stated she had discussed concerns with the monitoring and tracking of the supplements the last time she had visited in May with the DM, however, was not aware of follow up with her concerns.

During interview on 5/18/17, at 10:01 a.m. the DON stated the TMAs should be responsible for administering and tracking the supplements, however, further stated the process needed clarification. The DON reported the dietary staff also needed education on the process. The DON stated supplements were administered according to the individual's care plan, and there were a few

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| F 325 | Continued From page 13<br>that wanted it with meals. The DON stated she encouraged staff to administer supplements in between meals so residents received the extra caloric intake.<br><br>A facility policy entitled Nutrition (Impaired)/Unplanned Weight Loss- Clinical Protocol, revised 9/12, directed nutritional supplements would be used to increase intakes of nutrients and calories. Staff were responsible for "Evaluating the care plan to determine if the interventions are being implemented and whether they are effective in attaining the established nutritional and weight goals." | F 325 | | |
| F 329 SS=D | 483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--<br><br>(1) In excessive dose (including duplicate drug therapy); or<br><br>(2) For excessive duration; or<br><br>(3) Without adequate monitoring; or<br><br>(4) Without adequate indications for its use; or<br><br>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. | F 329 | | 6/27/17 |

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| (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 |
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| F 329 | Continued From page 14<br><br>483.45(e) Psychotropic Drugs.<br>Based on a comprehensive assessment of a resident, the facility must ensure that--<br><br>(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure target behaviors for antipsychotic medications were identified and monitored for 3 of 5 residents (R6, R24, R3) reviewed for unnecessary medications.<br><br>Findings include:<br><br>R6's quarterly MDS dated 3/14/17, indicated R6 had diagnoses including anxiety disorder and depression.<br><br>R6's diagnosis report undated, indicated diagnoses of diabetes, anxiety disorder, unspecified psychosis, schizoaffective disorder, and obsessive compulsive personality disorder.<br>An order summary report dated 5/18/17, indicated R6 was prescribed Rexulti (an antipsychotic used for the treatment of schizophrenia) 2 milligrams (mg) one time a day. R6's care plan dated 4/3/17, | F 329 | 1) Identify target behaviors of R6, R24, R3 by 6/15/17.<br>2) Assess all residents receiving antipsychotic medication and select target behaviors by 6/15/17.<br>3) Policy and procedure for target behaviors to be reviewed and updated by 6/15/17. Staff education to be completed by 6/15/17.<br>4) Audit residents receiving antipsychotic medications for targeted behaviors 2X/weekly for 4 weeks, then random monthly auditing. Results to be reported to QA committee. | |

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indicated R6 used psychotropic medication related to behavior management. The care plan indicated staff were to monitor for side effects and effectiveness of the psychotropic medication every shift as well as monitor change in behavior mood and cognition.

A review of R6's doctor's progress note dated 2/15/17, indicated R6 had been slightly more aggressive and had been having a hard time controlling her anger.

A review of R6's behavioral health note dated 3/22/17, indicated R6 was having auditory and visual hallucinations as well as being more impulsive with her internet searching, talking with strangers, and buying things on line.

A review of R6's record lacked documentation of observations or data collection related to target behavior monitoring to ascertain R6's response to the use of antipsychotic medication.

During an interview on 5/16/17, at 3:14 p.m. licensed practical nurse (LPN)-B stated they do not monitor target behaviors for the residents.

During an interview on 5/16/17, at 3:16 p.m. the director of nursing (DON) stated they do not document target behaviors for the psychotropic medications. The DON stated target behaviors were not tracked at this time.

R24's quarterly Minimum Data Set (MDS) dated 2/17/17, indicated R24 was severely cognitively impaired and had delusions (a belief or impression that is firmly maintained despite being contradicted by what is generally accepted as reality or rational argument). R24's diagnosis

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| F 329 | Continued From page 16<br>report dated 5/18/17, included the following diagnoses: unspecified dementia without behavioral disturbance, delusional disorder, and visual hallucinations.<br><br>R24's order summary report, dated 5/18/17, indicated a medication order for Seroquel (antipsychotic medication) 12.5 mg twice daily for delusions.<br><br>R24's care plan, revised on 2/21/17, directed staff to administer medication as ordered. To monitor/document/report as needed any signs and symptoms of depression, including: hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing of negative statements, repetitive anxious behavior, health-related complaints, and tearfulness. However, the care plan lacked monitoring related to hallucinations or delusions which was the indication for use of the Seroquel<br><br>A review of R24's medical record between the dates of 11/1/16 and 5/18/17, lacked documentation related to target behavior monitoring to establish the effectiveness of the Seroquel.<br><br>During an interview on 5/18/17, at 9:30 a.m. LPN-A stated target behaviors for antipsychotic medications used to be tracked, however, since the new computer system was started, target behaviors are no longer monitored.<br><br>During an interview on 5/18/17, at 2:25 p.m. the DON stated right now the facility's electronic charting system populates a generalized list for behavior monitoring. The list is generalized and not specific to a resident or medication. The DON | F 329 | | |

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| F 329 | Continued From page 17<br>stated it would be the expectation that target behaviors related to R24's Seroquel would be on the care plan. The DON reviewed R24's care plan and confirmed the care plan lacked target behaviors.<br><br>R3's quarterly MDS dated 3/6/17, identified R3 was cognitively intact, was often tired or had little energy, had no behaviors, hallucinations, or delusions, and received antipsychotic and antidepressant medications.<br><br>R3's admission record dated 8/31/07, included diagnosis of bipolar disorder.<br><br>R3's care plan dated 1/30/17, indicated R3 had a mood problem related to bipolar illness, history of delusion, and depressive disorder. The care plan directed staff to administer medications as ordered and to monitor/document for side effects and effectiveness. In addition, the care plan directed staff to monitor, record, and report to the medical doctor, any acute episode feelings or sadness, loss of pleasure and interest in activities, feelings of worthlessness or guilt, change in appetite or eating habits, change in sleep patterns diminished ability to concentrate, and change in psychomotor skills. Also included, staff were directed to observe for signs and symptoms of mania or hypomania racing thoughts or euphoria, increased irritability, frequent mood changes, pressured speech, flight of ideas, marked change in need for sleep, and agitation or hyperactivity.<br><br>R3's order summary report dated 5/18/17, indicated R3 was prescribed Risperdal (an antipsychotic medication used to treat bipolar disorder) 1.5 mg two times a day, and indicated | F 329 | | |

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| F 329 | Continued From page 18 | F 329 | | |

staff were to monitor for side effects of the antipsychotic medication every shift.

During an observation and interview on 5/17/17, at 2:13 p.m. R3 was in her room, sitting in a chair. R3 stated she ate lunch in her room because she "didn't want to deal with all those people." R3 talked about money, family, and her life when she was young, switching from subject to subject without pausing. R3 had a flat affect and spoke with a rambling, monotone voice.

Review of R3's doctor's progress note, dated 12/27/16, indicated R3 had "some paranoia but still not too bad." On 5/2/17, an Appleton Area Health Services physician note indicated R3 had bipolar disease, schizoaffective disorder and was on psychotropic medications, and was stable.

Review of R3's record lacked documentation related to target behavior monitoring to establish the effectiveness of the Risperdal.

During an interview on 5/18/17, at 9:34 a.m. LPN-A indicated target behavior monitoring had not been completed since the facility switched to an electronic medical record in November, 2016. LPN-A stated, "It somehow went away."

During an interview on 5/18/17, at 9:39 a.m. assistant director of nursing (ADON) stated, "When we switched over to the electronic system, things got missed." ADON indicated nurses were not documenting on target behaviors and stated, "We know we need to be working on that."

When interviewed on 5/18/17, at 12:08 p.m. consultant pharmacist (CP) stated when he visits the facility, he looks for documentation of why

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| F 329 | Continued From page 19<br>residents are receiving the ordered medications, reviews mood and behaviors that are being documented for consideration of a gradual dose reduction, and possible interactions. CP stated he discusses the residents with nursing staff and inquires about behaviors, moods, and what staff are seeing, and clarified concerns with the physician if needed. CP stated the staff do a nice job of documenting on some residents' behaviors and he asks questions about those he needs more information about. CP indicated he would be providing education to staff about monitoring and documenting target behaviors.<br><br>The facility policy Behavioral Assessment, Intervention and Monitoring dated 12/16 indicated interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities. The policy further identified when medication are prescribed for behavioral symptoms, documentation will include: specific target behaviors and expected outcomes. | F 329 | | |
| F 334 SS=D | 483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS<br><br>(d) Influenza and pneumococcal immunizations<br><br>(1) Influenza. The facility must develop policies and procedures to ensure that-<br><br>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br><br>(ii) Each resident is offered an influenza | F 334 | | 6/27/17 |

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| F 334 | Continued From page 20 | F 334 | | |

immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and

(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-

(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

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| F 334 | Continued From page 21<br><br>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:<br><br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br><br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure residents were offered and vaccinated with appropriate pneumococcal vaccines (Prevnar 13 and Pneumovax 23) for 2 of 5 residents (R1, R12) reviewed for immunizations.<br><br>Findings include:<br><br>R1 was admitted to the facility on 2/9/87, at the age of 46. R1's Minnesota Immunization Information Connection (MIIC) report identified R1 had a pneumococcal vaccination PCV13 (Prevnar 13) on 10/16/14, over two years prior, after the age of 65 years. R1's record lacked any information if the pneumococcal PPSV23 (Pneumovax 23) had been offered while in the facility to complete the pneumococcal series. No additional information was provided.<br><br>R12 was admitted to the facility on 2/17/17. R12's MIIC report identified R12 had a pneumococcal vaccination PPSV23 on 11/20/00, before the age | F 334 | 1) Offer PPSV23 to both R1 and R12 by 6/23/17.<br>2) Assess all residents for compliance by 6/23/17 and offer to all not in compliance.<br>3) Develop policy and procedure to ensure all new residents are assessed on admission for compliance with pneumococcal vaccines by 6/15/17. Staff education on 6/15/17.<br>4) Audit all new admits for compliance of new policy and procedure. Results to be reported to QA committee. | |

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| F 334 | Continued From page 22<br>of 65 years, and had received a pneumococcal vaccination PCV13 on 1/19/16, over a year before admission to the facility. R12's record lacked any indication if R12 had been offered an additional PPSV23 vaccination upon admission to the facility to complete the pneumococcal series. No additional information was provided.<br><br>During interview on 5/17/17, at 1:53 p.m. assistant director of nursing (ADON) stated the infection control program and associated vaccinations were part of a performance improvement project, and were working on revising the pneumococcal policy and procedures. The ADON stated the policies would be revised in stage two of the project, and the facility had not been aware of the regulations regarding Prevnar 13 until January 2017. The ADON reported they were currently talking with families during care conferences about the pneumococcal vaccinations. The ADON further reported new admissions were referred to the clinic to receive pneumococcal vaccinations and it was his responsibility to document the type of vaccination residents received. The ADON reviewed R1 and R12's MIIC reports and was unable to find additional documentation.<br><br>A facility policy entitled Administration of Pneumococcal Vaccine, undated, directed to screen all residents for contraindications to the vaccine, and administer PCV 7 (Prevnar vaccination), allowing for two months between doses of Prevnar 7 and other pneumococcal vaccinations. The policy did not address recommendations for PCV13 or PPSV23 vaccinations per current Center for Disease Control (CDC) recommendations. | F 334 | | |

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| F 356 SS=C | 483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION<br><br>483.35<br>(g) Nurse Staffing Information<br>(1) Data requirements. The facility must post the following information on a daily basis:<br><br>(i) Facility name.<br><br>(ii) The current date.<br><br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br><br>(A) Registered nurses.<br><br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law)<br><br>(C) Certified nurse aides.<br><br>(iv) Resident census.<br><br>(2) Posting requirements.<br><br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br><br>(ii) Data must be posted as follows:<br><br>(A) Clear and readable format.<br><br>(B) In a prominent place readily accessible to residents and visitors. | F 356 | | 6/27/17 |

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| F 356 | Continued From page 24<br><br>(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure the nurse staff posting was accurate and contained scheduled registered nursing staff hours. This had the potential to affect all 38 residents currently residing in the facility and their families.<br><br>Findings include:<br><br>During observation on 5/15/17, at 5:35 p.m. the facility's nurse staff posting, which showed the hours of licensed and non licensed staff working, was observed. The posting contained shifts from 6:00 a.m. to 2:00 p.m. (morning shift), 2:00 p.m. to 10:00 p.m. (evening shift), and 10:00 p.m. to 6:00 a.m. (night shift) with associated boxes for each category of licensed and non-licensed staff. The posting lacked documentation of 8 consecutive hours of registered nurse (RN) coverage, and all boxes next to "RN" were left blank across all three shifts.<br><br>During observation on 5/16/17, at 9:44 a.m. the nurse staff posting lacked documentation of RN coverage, with zeros next to the "RN" boxes for the morning and night shifts. The "RN" box was | F 356 | 1) Staff posting updated on 6/6/17 to include administration nursing hours to ensure all RN hours are posted.<br>2) Staff training on updated form will be completed by 6/15/17.<br>3) Audit of the staff posting will be conducted 3x weekly for four week, then random weekly audits. Results to be reported to QA committee. | |

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crossed out on the evening shift, and in its place two licensed practical nurses (LPN) were documented.

During observation on 5/17/17, at 7:20 a.m. the nurse staff posting again lacked documentation of RN coverage, with zeros next to the "RN" boxes for the morning and night shifts. The "RN" box was again crossed out on the evening shift, and in its place two LPNs were documented.

The licensed staffing schedule for the week of 5/15/17 to 5/18/17, was reviewed and identified the facility had at least eight consecutive hours of RN coverage between two RN nurse managers, assistant director of nursing (ADON), and a night RN nurse for weekend coverage.

During interview on 5/17/17, at 8:04 a.m. ADON stated the night nurses completed the nurse staff posting using the schedule book and had received direction that the RNs did not need to be reflected in the staff posting as long as they were on the schedule.

During interview on 5/17/17, at 11:07 a.m. DON stated she was not aware of a problem with the posting and thought what was posted on the staff posting met the requirements for the need on the floor.

A facility policy entitled Posting Direct Care Daily Staffing Numbers, revised 7/16, directed, "within two hours of the beginning of each shift, the number of Licensed Nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personal (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a

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| F 356 | Continued From page 26<br>clear and readable format." | F 356 | | |

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| **APPLETON MUNICIPAL HOSPITAL** | **30 SOUTH BEHL STREET**<br>**APPLETON, MN 56208** |

| (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<br><br>FIRE SAFETY<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Appleton Municipal Nursing Home was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES<br>( K-TAGS) TO:<br><br>Health Care Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145<br>St Paul, MN 55101-5145, or | K 000 | EPOC | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 06/09/2017 |

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

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| | 245231 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **05/16/2017** |

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| K 000 | Continued From page 1<br>By email to:<br>Marian.Whitney@state.mn.us and<br>Angela.Kappenman@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency<br><br>Appleton Municipal Nursing Home is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1964 and was determined to be of Type II(000) construction. In 1976, an addition was added to the east that was determined to be of Type II(222). In 1992 an addition was added to the southeast that was determined to be of Type II(000) construction. Because the original building and the additions meet the construction type allowed for a Type II (000) existing building, the facility was surveyed as one building.<br><br>The building is fully sprinklered throughout. the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 38 at the time of the survey. | K 000 | | |

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| K 000 | Continued From page 2<br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 345 SS=F | NFPA 101 Fire Alarm System - Testing and Maintenance<br><br>Fire Alarm System - Testing and Maintenance<br>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br><br>This STANDARD is not met as evidenced by:<br>Based on documentation review and interview, the Facility failed to test and maintain the Fire Alarm System in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. The deficient practice could affect 38 out of 38 residents.<br><br>Fire Alarm System - Testing and Maintenance<br>A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25.<br><br>Findings include: | K 345 | A plan of correction had been implemented prior to inspection. Amery Longman, maintenance manager, a qualified party, will be responsible for all fire testing and drills.<br><br>This plan was implemented in February, 2017 and has 5 correctly documented months currently available and will continue to be reviewed by our QA team. | 6/27/17 |

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| K 345 | Continued From page 3<br>On facility tour between 9 AM and 1:00 PM on 05/16/2017, documentation reviewed revealed that the DACT System was not tested monthly during the following times:<br><br>1) 1st quarter 3rd shift of 2017<br>2) all shifts third quarter in 2016<br>3) 2nd and 3rd shift fourth quarter 2016<br><br>This deficient practice was verified by the Facility Maintenance Director. | K 345 | | |
| K 353 SS=D | NFPA 101 Sprinkler System - Maintenance and Testing<br><br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This STANDARD is not met as evidenced by:<br>Based on a review of documentation and an interview with staff, it was determined that the Sprinkler Suppression system is not in accordance with NFPA 101 The Life Safety Code | K 353 | Amery Longman on behalf of facility will contact Simplex Grinnel, a qualified contractor, by 06/27/17, to install a new, paint-free, sprinkler head. Amery | 6/27/17 |

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| K 353 | Continued From page 4<br>(edition 2012), Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems.<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br><br>Findings Include:<br>On facility tour between 9 AM and 1:00 PM on 05/16/2017, observations revealed there is 1 sprinkler head that is painted across from the pump room.<br><br>This deficient practice was verified by the Facility Maintenance Director. | K 353 | Longman will also conduct further education regarding sprinkler heads with staff responsible for painting in the facility by 06/27/17 to ensure it does not happen again. | |
| K 712<br>SS=F | NFPA 101 Fire Drills<br><br>Fire Drills<br>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.<br>18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7<br>This STANDARD is not met as evidenced by: | K 712 | | 6/27/17 |

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| K 712 | Continued From page 5<br>Based on record review and staff interview the facility failed to provide documentation of fire drills at least quarterly on each shift as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all residents and an undetermined amount of staff and visitors.<br><br>Findings include:<br><br>On facility tour between 9 AM and 1:00 PM on 05/16/2017, documentation reviewed revealed that Fire drills were not performed during these times:<br><br>1) 1st quarter 3rd shift of 2017<br>2) all shifts third quarter in 2016<br>3) 2nd and 3rd shift fourth quarter 2016<br><br>This deficient practice was verified by the Facility Maintenance Director. | K 712 | The plan of correction was implemented prior to survey in February, 2017. Amery Longman, maintenance manager, a qualified party, will be responsible for correct procedure and documentation regarding all fire drills. This plan had 5 documented months of fire drills done according to requirements and will continue to be monitored by our QA team. | |
| K 923 SS=D | NFPA 101 Gas Equipment - Cylinder and Container Storag<br><br>Gas Equipment - Cylinder and Container Storage<br>Greater than or equal to 3,000 cubic feet<br>Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.<br>>300 but <3,000 cubic feet<br>Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are | K 923 | | 6/27/17 |

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| K 923 | Continued From page 6<br>separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.<br>Less than or equal to 300 cubic feet<br>In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.<br>A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."<br>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.<br>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)<br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview the facility failed to store oxygen tanks in accordance with NFPA 99 (Health Care Facilities Code) 2012 edition section 11.6.2.3 item 11. This deficient practice could create an oxygen filled atmosphere and accelerate the spread of fire. This condition could affect all of the 38 residents and an undetermined amount of staff and visitors.<br><br>Findings include:<br><br>On facility tour between 9 AM and 1:00 PM on 05/16/2017, observations revealed and staff | K 923 | The oxygen storage area deficiency was corrected immediately. Separate racks were implemented for storage of full and empty E-cylinders and each rack has appropriate signage indicating storage of full and empty e-cylinders.<br><br>Free standing e-cylinder was removed immediately from room 108.<br><br>Staff were instructed the same day that there should be no free standing e-cylinders anywhere within the facility | |

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| K 923 | Continued From page 7<br>interview revealed:<br><br>1) Full and empty oxygen tanks combined in the same area.<br>2) RM 108 had a free standing E Cylinder next to a chair.<br><br>This deficient practice was verified by the Facility Maintenance Director. | K 923 | and about the separation of the full and empty E-cylinders.<br><br>Reinforcement of the changes will be done at the nursing staff meeting on 06/15/17. | |