

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 1PTN
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
4. TYPE OF ACTION: 7 (L8)
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY 06/06/2016 (L34)
7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
8. ACCREDITATION STATUS: (L10)
10. THE FACILITY IS CERTIFIED AS: X A. In Compliance With
11. LTC PERIOD OF CERTIFICATION
12. Total Facility Beds 50 (L18)
13. Total Certified Beds 50 (L17)
14. LTC CERTIFIED BED BREAKDOWN
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 Brenda Fischer, Unit Supervisor Date: 06/06/2016 (L19)
18. STATE SURVEY AGENCY APPROVAL Kate JohnsTon, Program Specialist Date: 06/29/2016 (L20)

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

19. DETERMINATION OF ELIGIBILITY
20. COMPLIANCE WITH CIVIL RIGHTS ACT:
21. 1. Statement of Financial Solvency (HCFA-2572)
22. ORIGINAL DATE OF PARTICIPATION 08/01/1982 (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)
26. TERMINATION ACTION: 00 (L30)
27. ALTERNATIVE SANCTIONS
28. TERMINATION DATE: (L28)
29. INTERMEDIARY/CARRIER NO. 03001 (L31)
30. REMARKS Posted 07/14/2016 Co.
31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE 05/31/2016 (L33)
DETERMINATION APPROVAL



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245231  
June 29, 2016

Mr. Jeffrey Cook, Administrator  
Appleton Municipal Hospital  
30 South Behl Street  
Appleton, Minnesota 56208

Dear Mr. Cook:

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 5, 2016 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.

Appleton Municipal Hospital

June 29, 2016

Page 2

Sincerely,

A handwritten signature in black ink, appearing to read "Kate Johnston". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Kate JohnsTon, Program Specialist  
Program Assurance Unit  
Licensing and Certification Program  
Health Regulation Division  
85 East Seventh Place, Suite 220  
P.O. Box 64900  
St. Paul, Minnesota 55164-0900  
kate.johnston@state.mn.us  
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered  
June 29, 2016

Mr. Jeffrey Cook, Administrator  
Appleton Municipal Hospital  
30 South Behl Street  
Appleton, Minnesota 56208

RE: Project Number S5231026

Dear Mr. Cook:

On May 5, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 21, 2016. 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 June 6, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 4, 2016 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 April 21, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 5, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 21, 2016, effective June 5, 2016 and therefore remedies outlined in our letter to you dated May 5, 2016, 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.

Appleton Municipal Hospital

June 29, 2016

Page 2

Sincerely,

A handwritten signature in black ink that reads "Kate Johnston". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Kate JohnsTon, Program Specialist  
Program Assurance Unit  
Licensing and Certification Program  
Health Regulation Division  
85 East Seventh Place, Suite 220  
P.O. Box 64900  
St. Paul, Minnesota 55164-0900  
kate.johnston@state.mn.us  
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 245231	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 6/6/2016	Y3
NAME OF FACILITY APPLETON MUNICIPAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 30 SOUTH BEHL STREET APPLETON, MN 56208		

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241	Correction	ID Prefix F0354	Correction	ID Prefix	Correction
Reg. # 483.15(a)	Completed	Reg. # 483.30(b)	Completed	Reg. #	Completed
LSC	06/05/2016	LSC	06/05/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS) BF/KJ	DATE 06/29/2016	SIGNATURE OF SURVEYOR 10562	DATE 06/06/2016
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 4/21/2016		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>		

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 245231	Y1	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	DATE OF REVISIT 6/4/2016	Y3
NAME OF FACILITY APPLETON MUNICIPAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 30 SOUTH BEHL STREET APPLETON, MN 56208		

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0029	05/20/2016	LSC K0069	06/01/2016	LSC K0144	05/11/2016
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS) BF/KJ	DATE 06/29/2016	SIGNATURE OF SURVEYOR 10562	DATE 06/04/2016
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 4/19/2016	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?	<input type="checkbox"/> YES <input type="checkbox"/> NO
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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered  
May 5, 2016

Mr. Jeffrey Cook, Administrator  
Appleton Municipal Hospital  
30 South Behl Street  
Appleton, Minnesota 56208

RE: Project Number S5231026

Dear Mr. Cook:

On April 21, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

#### **DEPARTMENT CONTACT**

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

**Jessica Sellner, Unit Supervisor  
Minnesota Department of Health  
St. Cloud B Survey Team  
Licensing & Certification  
Health Regulation Division  
Midtown Square  
3333 West Division, #212  
St. Cloud, Minnesota 56301  
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 May 31, 2016, 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 May 31, 2016 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 July 21, 2016 (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 October 21, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

### **INFORMAL DISPUTE RESOLUTION**

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

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

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

Appleton Municipal Hospital

May 5, 2016

Page 6

444 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,

A handwritten signature in cursive script that reads "Kate Johnston". The signature is written in black ink and is positioned below the word "Sincerely,".

Kate JohnSTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

85 East Seventh Place, Suite 220

P.O. Box 64900

St. Paul, Minnesota 55164-0900

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245231</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/21/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>APPLETON MUNICIPAL HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>30 SOUTH BEHL STREET APPLETON, MN 56208</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.  Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure dignity was maintained for 1 of 1 residents (R11) whose urinary catheter bag was uncovered and visible to other residents, visitors, and/ or family members at the facility. Findings include: R11's quarterly Minimum Data Set (MDS) dated 3/22/16, indicated the resident had no cognitive impairment, required extensive assistance with dressing, toileting, personal hygiene, and was independent with walking on and off the unit.	F 241	1) Resident #11 has a new catheter bag cover ordered that will hold catheter off the floor and cover the bag. Another cover will be placed in reserve.  2) Facility policy and procedure for catheter care will be reviewed and revised. All nursing staff will be re-inserviced on policy and procedure. Residents will be monitored daily by licensed nurses for catheter placement. Random audits will be performed 3X/week for one month, then 1X/week for	6/5/16	

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

TITLE

(X6) DATE

Electronically Signed

05/13/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245231</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/21/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>APPLETON MUNICIPAL HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>30 SOUTH BEHL STREET APPLETON, MN 56208</b>		
(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 241	Continued From page 1 During observation on 4/18/16, at 1:57 p.m. R11 was seated in the recliner in her room and the catheter bag was lying on the floor uncovered. The catheter tubing was observed coming out of R11's right pant leg, and urine was present in the tubing, and the catheter bag was about half full of urine. R11 stated she was embarrassed when the nursing assistants did not cover the drainage bag of the catheter because others were able to see the urinary catheter and urine.  During an interview on 4/20/16, at 8:11 a.m. nursing assistant (NA)-A stated R11's catheter bag should be covered at all times so it is not visible to others.  On 4/20/16, at 8:21 a.m. the interim director of nursing (IDON) stated R11's catheter bag should be covered so it is not visible to others.  During interview on 4/20/16, at 11:07 a.m. licensed practical nurse (LPN)-B verified staff should be covering R11's catheter bag so it is not visible to others.  A policy regarding dignity and/ or applying a cover to the catheter bag was requested but not provided.	F 241	compliance.  3) DON or designee is responsible for overall compliance. Results of audit will be communicated to facility QA committee.  4) The facility alleges that it will be in substantial compliance by 06/05/16.		
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON  Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.  Except when waived under paragraph (c) or (d) of this section, the facility must designate a	F 354		6/5/16	



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

PRINTED: 05/13/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245231</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/21/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>APPLETON MUNICIPAL HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>30 SOUTH BEHL STREET APPLETON, MN 56208</b>		
(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 354	<p>Continued From page 2</p> <p>registered nurse to serve as the director of nursing on a full time basis.</p> <p>The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide registered nurse coverage for 8 consecutive hours, 7 days a week. This had the potential to affect all 43 residents who resided in the facility. Findings include:</p> <p>The facility staffing schedules reviewed from 11/15, through 3/16, indicated there were 8 days where the required 8/hours in 24 hour period RN coverage was not scheduled on the following days: 11/28/15, 11/29/16, 12/19/16,12/20/16, 12/25/16, 1/9/16, 2/21/16, and 3/12/16.</p> <p>During interview on 4/21/16, at 8:40 a.m. licensed practical nurse (LPN)-A and director of nursing (DON) stated on 2/21/16 , there was no RN coverage in the facility, but used the RN working at the hospital for back up if needed. The DON stated the schedules indicated there had been no RN coverage from 3/12/16, at 6 a.m. until 3/13/16, at 6 p.m., however, she was unsure why there had not been and RN coverage scheduled.</p> <p>A policy regarding RN coverage was requested but not provided.</p>	F 354	<p>1) Facility policy and procedure will be reviewed and revised for staffing. Licensed nursing staff will be re-inserviced on facility policy and procedure.</p> <p>2) Daily monitoring of licensed staff schedule will be performed by DON/designee.</p> <p>3) DON or designee is responsible for overall compliance.</p> <p>4) The facility alleges that it will be in substantial compliance by 06/05/16.</p>		

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

F5231024

PRINTED: 05/18/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245231</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/19/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>APPLETON MUNICIPAL HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>30 SOUTH BEHL STREET APPLETON, MN 56208</b>
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K 000	<p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>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.</p> <p>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.</p> <p>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 substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES ( K-TAGS) TO:</p> <p>Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or</p> <p>By email to:</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE <b>05/13/2016</b>
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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

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K 000	<p>Continued From page 1</p> <p>Marian.Whitney@state.mn.us &lt;mailto:Marian.Whitney@state.mn.us&gt; and Angela.Kappenman@state.mn.us &lt;mailto:Angela.Kappenman@state.mn.us&gt;</p> <p>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:</p> <ol style="list-style-type: none"> <li>1. A description of what has been, or will be, done to correct the deficiency.</li> <li>2. The actual, or proposed, completion date.</li> <li>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency</li> </ol> <p>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.</p> <p>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 43 at the time of the survey.</p>	K 000		

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K 000	Continued From page 2	K 000		
K 029 SS=D	<p>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>One hour fire rated construction (with 0 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</p> <p>This STANDARD is not met as evidenced by:</p> <p>One hour fire rated construction (with 0 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</p> <p>On facility tour between 10:30 AM to 2:00 PM on 04/19/2016, observations revealed the following deficient condition was identified:</p> <p>1) The door to the CSR Storage did not have a closure.</p> <p>This deficient practices was confirmed by the Facility Maintance Director (AL).</p>	K 029	<p>One-hour fire rated doors with appropriate closures have been ordered through Kranz Construction. The install will be completed by Kranz Construction, a qualified party, by 05/20/16. This process will be overseen by Amery Longman, Environmental Services Manager.</p>	5/20/16

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K 069 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>Findings Include:</p> <p>On facility tour between 10:30 AM to 2:00 PM on 04/19/2016, during the review of all available documentation for the kitchen hood ventilation system inspection reports the facility could not provide documentation showing that the hood suppression system has been completely cleaned and professionally inspected within the last six month prior to the previous inspection. At the time of the inspection the last inspection of the kitchen hood ventilation system was conducted on 02/02/2016, prior to that inspection the previous inspection was done on 02/2015.</p>	K 069	<p>Simplex Grinnell, a certified party, has been notified of the deficiency and asked in inspect the kitchen hood as soon as possible to put us back on our prior schedule. The next inspection will be performed before 06/01/16 and again in October, 2016. This will be verified by Amery Longman, Environmental Services Manager.</p>	6/1/16
K 144 SS=C	<p>This deficient practices was confirmed by the Facility Maintance Director (AL).</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>This STANDARD is not met as evidenced by: Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>Findings include:</p>	K 144	<p>Documentation of the cool down will be performed by AAHS techs upon generator inspections starting immediately (05/11/16). This will be verified by Amery Longman, Environmental Services Manager.</p>	5/11/16

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K 144	Continued From page 4  On facility tour between 10:30 AM to 2:00 PM on 04/19/2016, during the review of all available documentation for the emergency generator, revealed the facility did not document the required cool down for the emergency generator.  This deficient practices was confirmed by the Facility Maintance Director (AL).	K 144		



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted  
May 5, 2016

Mr. Jeffrey Cook, Administrator  
Appleton Municipal Hospital  
30 South Behl Street  
Appleton, Minnesota 56208

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5231026

Dear Mr. Cook:

The above facility was surveyed on April 18, 2016 through April 21, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

Appleton Municipal Hospital

May 5, 2016

Page 2

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Jessica Sellner, Unit Supervisor at (320) 223-7343.

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

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

Please feel free to call me with any questions.

Sincerely,



Kate JohnsTon, Program Specialist  
Program Assurance Unit  
Licensing and Certification Program  
Health Regulation Division  
85 East Seventh Place, Suite 220  
P.O. Box 64900  
St. Paul, Minnesota 55164-0900  
kate.johnston@state.mn.us  
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File



Appleton Municipal Hospital

May 5, 2016

Page 3

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00655</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2016</b>
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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p><b>NH LICENSING CORRECTION ORDER</b></p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p><b>INITIAL COMMENTS:</b> You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a> The State licensing orders are delineated on the attached Minnesota</p>	2 000		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE  
05/13/16

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00655</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2016</b>
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2 000	<p>Continued From page 1</p> <p>Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.</p> <p>On April 18, 19, 20, 21 of 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.</p> <p>The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p>	2 000		

Minnesota Department of Health

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2 000	Continued From page 2	2 000		
21805	<p>MN St. Statute 144.651 Subd. 5 Patients &amp; Residents of HC Fac. Bill of Rights</p> <p>Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure dignity was maintained for 1 of 1 residents (R11) whose urinary catheter bag was uncovered and visible to other residents, visitors, and/ or family members at the facility. Findings include: R11's quarterly Minimum Data Set (MDS) dated 3/22/16, indicated the resident had no cognitive impairment, required extensive assistance with dressing, toileting, personal hygiene, and was independent with walking on and off the unit.</p> <p>During observation on 4/18/16, at 1:57 p.m. R11 was seated in the recliner in her room and the catheter bag was lying on the floor uncovered. The catheter tubing was observed coming out of R11's right pant leg, and urine was present in the tubing, and the catheter bag was about half full of urine. R11 stated she was embarrassed when the nursing assistants did not cover the drainage bag of the catheter because others were able to</p>	21805	Corrected.	5/26/16

Minnesota Department of Health

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21805	<p>Continued From page 3</p> <p>see the urinary catheter and urine.</p> <p>During an interview on 4/20/16, at 8:11 a.m. nursing assistant (NA)-A stated R11's catheter bag should be covered at all times so it is not visible to others.</p> <p>On 4/20/16, at 8:21 a.m. the interim director of nursing (IDON) stated R11's catheter bag should be covered so it is not visible to others.</p> <p>During interview on 4/20/16, at 11:07 a.m. licensed practical nurse (LPN)-B verified staff should be covering R11's catheter bag so it is not visible to others.</p> <p>A policy regarding dignity and/ or applying a cover to the catheter bag was requested but not provided.</p> <p><b>SUGGESTED METHOD OF CORRECTION:</b> The director of nursing, or designee, could review and revise policies and procedures related to dignity and provision of care, and provide staff education on providing dignified care. The director of nursing or designee could develop an audit tool to ensure dignified resident care is provided.</p> <p><b>TIME PERIOD FOR CORRECTION:</b> Twenty-one (21) days.</p>	21805		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00655</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>APPLETON MUNICIPAL HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>30 SOUTH BEHL STREET APPLETON, MN 56208</b>
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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) COMPLETE DATE
2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a> The State licensing orders are delineated on the attached Minnesota</p>	2 000		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00655</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>APPLETON MUNICIPAL HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>30 SOUTH BEHL STREET APPLETON, MN 56208</b>
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2 000	<p>Continued From page 1</p> <p>Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.</p> <p>On April 18, 19, 20, 21 of 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.</p> <p>The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p>	2 000		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00655</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/21/2016</b>
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2 000	Continued From page 2	2 000		
21805	<p>MN St. Statute 144.651 Subd. 5 Patients &amp; Residents of HC Fac.Bill of Rights</p> <p>Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure dignity was maintained for 1 of 1 residents (R11) whose urinary catheter bag was uncovered and visible to other residents, visitors, and/ or family members at the facility. Findings include: R11's quarterly Minimum Data Set (MDS) dated 3/22/16, indicated the resident had no cognitive impairment, required extensive assistance with dressing, toileting, personal hygiene, and was independent with walking on and off the unit.</p> <p>During observation on 4/18/16, at 1:57 p.m. R11 was seated in the recliner in her room and the catheter bag was lying on the floor uncovered. The catheter tubing was observed coming out of R11's right pant leg, and urine was present in the tubing, and the catheter bag was about half full of urine. R11 stated she was embarrassed when the nursing assistants did not cover the drainage bag of the catheter because others were able to</p>	21805		



Minnesota Department of Health

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