CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 1PTN

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

		PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY	AGENCY	F	acility ID: 00655
1. MEDICARE/MEDICAID PH (L1) 245231 2.STATE VENDOR OR MEDI (L2) 705040200			3. NAME AND ADD (L3) APPLETON (L4) 30 SOUTH B (L5) APPLETON,	MUNICIPAL HO EHL STREET			(L6) 56208	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	7 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANG (L9)	GE OF OWNERSHIP		7. PROVIDER/SUF	PPLIER CATEGORY	Y 09 ESRD	02 13 PTIP	(L7) 22 CLIA	7. On-Site Visit 8. Full Survey After Con	9. Other
DATE OF SURVEY ACCREDITATION STATUS Unaccredited AOA	06/06/2016 S: 1 TJC 3 Other	(L34) _ (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPIG	CE	FISCAL YEAR ENDING 09/30	DATE: (L35)
11. LTC PERIOD OF CERTIFIED From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BRITE 18 SNF (L37)	50 50	(L18) (L17) 19 SNF (L39)	B. Not in Com	nce With quirements		2 3 4 5. * Code:	Technical Personnel 24 Hour RN 7-Day RN (Rural SNF) Life Safety Code A*	Following Requirements: 6. Scope of Servi 7. Medical Direct 8. Patient Room S 9. Beds/Room (L12) (L15)	or
16. STATE SURVEY AGENC		PLICABLE S		ATION DATE):					
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	PAR	T II - TO	BE COMPLETE	D BY HCFA RI	EGIONAL	OFFICE (OR SINGLE STAT	E AGENCY	
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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,

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,

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 1PTN

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

	PART	I - TO BE COM	PLETED BY T	HE STAT	E SURVEY	AGENCY	F	Facility ID: 00655
MEDICARE/MEDICAID PROVIDER (L1) 245231 2.STATE VENDOR OR MEDICAID NO (2) 705040300		3. NAME AND AD (L3) APPLETON (L4) 30 SOUTH B	MUNICIPAL HO BEHL STREET			T. O. 5(200	4. TYPE OF ACTION: 1. Initial 3. Termination	2 (L8) 2. Recertification 4. CHOW
(L2) 705040200 5. EFFECTIVE DATE CHANGE OF OV (L9)	VNERSHIP	7. PROVIDER/SUI	*	Y 09 ESRD		(L7) 22 CLIA	5. Validation 7. On-Site Visit 8. Full Survey After Co	6. Complaint 9. Other mplaint
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25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI A. Suspension of B. Rescind Suspension of the sus	of Admissions:	(L44)			avoluntary Termination ason for Withdrawal	OTHER 07-Provider 00-Active	Status Change
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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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

Fax: (320)223-7348

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

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

> 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,

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

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

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

NAME OF PROVIDER OR SUPPLIER APPLETON MUNICIPAL HOSPITAL INTEGRATION OF LIST DEPTICIENCIES PREFIX PREFIX PROVIDERS PLAN OF CORRECTION PRICE PROVIDERS PLAN OF CORRECTION PROVIDED		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG		E SURVEY PLETED
APPLETON MUNICIPAL HOSPITAL XA) ID SUMMARY STATEMENT OF DEFICIENCIES FROVIDERS PLAN OF CORRECTION FREGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX FACE FROVIDERS PLAN OF CORRECTION FREGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX FACE FROVIDERS PLAN OF CORRECTION FREGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX FACE FACE			245231	B. WING		04/	21/2016
FREEDLY TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FOOD 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 with the regulations has been attained in accordance with your verification. F 241 483.15(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 this 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, tolleting, personal hygiene, and was independent with walking on and off the unit.			PITAL		30 SOUTH BEHL STREET	CODE	
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 241 483.15(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.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE IE APPROPRIATE	COMPLETION
dressing, toileting, personal hygiene, and was independent with walking on and off the unit. Continue of the unit of the un	F 000	INITIAL COMMENT The facility's plan of as your allegation of Department's accept enrolled in ePOC, yat the bottom of the form. Your electron be used as verificated. Upon receipt of an on-site revisit of you validate that substate regulations has been your verification. 483.15(a) DIGNITY INDIVIDUALITY The facility must promanner and in an even thances each restriction of his process full recognition of his process full recognition of his maintained for 1 of urinary catheter based on observating the facility. Findings include: R11's quarterly Min 3/22/16, indicated to the process full recognition of his review the facility farmaintained for 1 of urinary catheter based on the facility. Findings include: R11's quarterly Min 3/22/16, indicated the second recognition of his process full recognition of his process full recognition of his review the facility farmaintained for 1 of urinary catheter based on the facility. Findings include: R11's quarterly Min 3/22/16, indicated the process full recognition of his	of correction (POC) will serve frompliance upon the otance. Because you are rour signature is not required first page of the CMS-2567 are submission of the POC will ion of compliance. Cacceptable electronic POC, an air facility may be conducted to intial compliance with the en attained in accordance with AND RESPECT OF Comote care for residents in a invironment that maintains or ident's dignity and respect in sor her individuality. Note that is not met as evidenced ion, interview, and document ided to ensure dignity was a residents (R11) whose gives uncovered and visible to tors, and/ or family members imum Data Set (MDS) dated the resident had no cognitive	F 0	1) Resident #11 has a necover ordered that will hole the floor and cover the bacover will be placed in res 2) Facility policy and procatheter care will be review revised. All nursing staff were-inserviced on policy and	ew catheter bag d catheter off g. Another erve. edure for wed and will be d procedure.	6/5/16
	ADODATOS	dressing, toileting, prindependent with w	personal hygiene, and was alking on and off the unit.	JATURE .	licensed nurses for cathet Random audits will be per	er placement. formed 3X/week	(X6) DATE

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

TITLE

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.

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

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY PLETED
		245231	B. WING		04/	21/2016
	PROVIDER OR SUPPLIER ON MUNICIPAL HOSE	PITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 30 SOUTH BEHL STREET APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 241	was seated in the recatheter bag was ly The catheter tubing R11's right pant leg tubing, and the cathurine. R11 stated s the nursing assistar bag of the catheter see the urinary cath	on 4/18/16, at 1:57 p.m. R11 ecliner in her room and the ring on the floor uncovered. was observed coming out of, and urine was present in the neter bag was about half full of the was embarrassed when the het of the was embarrassed when the did not cover the drainage because others were able to neter and urine.	F 24	compliance. 3) DON or designee is responsible overall compliance. Results of aud be communicated to facility QA committee. 4) The facility alleges that it will be substantial compliance by 06/05/10	dit will	
	nursing assistant (N bag should be covered to others. On 4/20/16, at 8:21 nursing (IDON) stat be covered so it is rursing interview on licensed practical n	on 4/20/16, at 8:11 a.m. NA)-A stated R11's catheter ered at all times so it is not I a.m. the interim director of ed R11's catheter bag should not visible to others. 4/20/16, at 11:07 a.m. urse (LPN)-B verified staff R11's catheter bag so it is not				
	to the catheter bag provided. 483.30(b) WAIVER FULL-TIME DON	dignity and/ or applying a cover was requested but not -RN 8 HRS 7 DAYS/WK,	F 35	4		6/5/16
	this section, the fac registered nurse for a day, 7 days a wee Except when waive	d under paragraph (c) or (d) of ility must use the services of a r at least 8 consecutive hours ek. d under paragraph (c) or (d) of ility must designate a				

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

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

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		TE SURVEY MPLETED
		245231	B. WING _	·····	04	/21/2016
	PROVIDER OR SUPPLIER ON MUNICIPAL HOSE	PITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 30 SOUTH BEHL STREET APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 354	registered nurse to nursing on a full time. The director of nursinurse only when the occupancy of 60 or This REQUIREMENT by: Based on interview facility failed to proving the potential to affein the facility. Findings include: The facility staffing 11/15, through 3/16 where the required coverage was not stays: 11/28/15, 11/2 12/25/16, 1/9/16, 2/2 During interview on practical nurse (LPI (DON) stated on 2/2 coverage in the facat the hospital for bestated the schedule RN coverage from 3/13/16, at 6 p.m., I there had not been	serve as the director of the basis. sing may serve as a charge the facility has an average daily	F 35	1) Facility policy and procedure reviewed and revised for staffin Licensed nursing staff will be re-inserviced on facility policy a procedure. 2) Daily monitoring of licensed schedule will be performed by DON/designee. 3) DON or designee is respons overall compliance. 4) The facility alleges that it will substantial compliance by 06/05	g. nd staff sible for I be in	

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

F5231024

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

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245231 B. WING 04/19/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 30 SOUTH BEHL STREET APPLETON MUNICIPAL HOSPITAL APPLETON, MN 56208 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRÉ SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES** (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to:

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.

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

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ECONSTRUCTION 11 - MAIN BUILDING 01		E SURVEY PLETED
		245231	B. WING	-		04/	19/2016
	PROVIDER OR SUPPLIER ON MUNICIPAL HOSI	PITAL		30	REET ADDRESS, CITY, STATE, ZIP CODE SOUTH BEHL STREET PPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Angela.Kappenmal <mailto:angela.kap 1.="" 2.="" 3.="" a="" actual,="" and="" co="" correct="" correctors<="" defic="" deficiency="" description="" following="" for="" info="" mus="" name="" of="" or="" oresponsible="" plan="" pr="" td="" the="" to=""><td>state.mn.us itney@state.mn.us> and n@state.mn.us openman@state.mn.us> RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done</td><td>K</td><td>0000</td><td>DEFICIENCITY</td><td></td><td></td></mailto:angela.kap>	state.mn.us itney@state.mn.us> and n@state.mn.us openman@state.mn.us> RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done	K	0000	DEFICIENCITY		
	building with a part constructed at 3 dit building was constructed to be of 1976, an addition with determined to be of addition was added determined to be of Because the origin meet the construct (000) existing build as one building. The building is fully facility has a fire all detection in the concorridors that is more department notifical.	I Nursing Home is a 1-story ial basement. The building was fferent times. The original ructed in 1964 and was if Type II(000) construction. In was added to the east that was if Type II(222). In 1992 and to the southeast that was if Type II(000) construction. al building and the additions ion type allowed for a Type II ling, the facility was surveyed or sprinklered throughout. The facility was surveyed arm system with smoke rridors and spaces open to the positored for automatic fire ation. The facility has a seand had a census of 43 at the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00655

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

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	LTIPLE CONSTRUCTION (X: DING 01 - MAIN BUILDING 01		E SURVEY PLETED	
		245231	B. WING			04/	19/2016
	PROVIDER OR SUPPLIER ON MUNICIPAL HOSI	PITAL		30	REET ADDRESS, CITY, STATE, ZIP CODE DISOUTH BEHL STREET PPLETON, MN 56208		Þ
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000		t 42 CFR, Subpart 483.70(a) is	K	000			
K 029 SS=D	One hour fire rated fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro the approved autor option is used, the other spaces by sn doors. Doors are sfield-applied proted 48 inches from the permitted. 19.3.2 This STANDARD in One hour fire rated fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro the approved autor option is used, the other spaces by sn doors. Doors are sfield-applied proted 48 inches from the permitted. 19.3.2 On facility tour betwo 4/19/2016, observed ficient conditions.	I construction (with o hour an approved automatic fire an in accordance with 8.4.1 stects hazardous areas. When matic fire extinguishing system areas are separated from noke resisting partitions and self-closing and non-rated or stive plates that do not exceed bottom of the door are 2.1 is not met as evidenced by: doonstruction (with o hour an approved automatic fire an in accordance with 8.4.1 stects hazardous areas. When matic fire extinguishing system areas are separated from noke resisting partitions and self-closing and non-rated or stive plates that do not exceed bottom of the door are 2.1 Ween 10:30 AM to 2:00 PM on vations revealed the following was identified: CSR Storage did not have a	K	029	One-hour fire rated doors with appropriate closures have been ord through Kranz Construction. The ir will be completed by Kranz Construa qualified party, by 05/20/16. This process will be overseen by Amery Longman, Environmental Services Manager.	nstall iction,	5/20/16

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00655

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

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION D1 - MAIN BUILDING 01	(X3) DATE COMF	PLETED
		245231	B. WING			04/1	9/2016
	ROVIDER OR SUPPLIER N MUNICIPAL HOSE	PITAL		30	TREET ADDRESS, CITY, STATE, ZIP CODE SOUTH BEHL STREET PPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
SS=D ()	Cooking facilities at with 9.2.3. 19.3.2 This STANDARD i Cooking facilities a with 9.2.3. 19.3.2 Findings Include: On facility tour betw 04/19/2016, during documentation for system inspection is provide documenta suppression system and professionally month prior to the ptime of the inspecti kitchen hood ventilion 02/02/2016, prioprevious inspection. This deficient pract Facility Maintance NFPA 101 LIFE SA Generators inspection accordance with 3-4.4.1 and 8-4.2 (110) This STANDARD in accordance with 10 Generators inspection of the inspection of th	s not met as evidenced by: are protected in accordance 2.6, NFPA 96 ween 10:30 AM to 2:00 PM on the review of all available the kitchen hood ventilation reports the facility could not ation showing that the hood in has been completely cleaned inspected within the last six previous inspection. At the on the last inspection of the ation system was conducted or to that inspection the in was done on 02/2015.	K	144	Simplex Grinnell, a certified party, been notified of the deficiency and in inspect the kitchen hood as soon possible to put us back on our prior schedule. The next inspection will performed before 06/01/16 and ago October, 2016. This will be verified Amery Longman, Environmental Semanager. Documentation of the cool down was performed by AAHS techs upon ge inspections starting immediately (05/11/16). This will be verified by Longman, Environmental Services Manager.	has asked as be ain in by ervices vill be enerator Amery	5/11/16

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

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01	(X3) DAT	TE SURVEY MPLETED
		245231	B, WING	3	04	/19/2016
	PROVIDER OR SUPPLIER ON MUNICIPAL HOSE	PITAL		STREET ADDRESS, CITY, STATE, ZIP CO 30 SOUTH BEHL STREET APPLETON, MN 56208	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
K 144	On facility tour betw 04/19/2016, during documentation for t revealed the facility cool down for the e	ween 10:30 AM to 2:00 PM on the review of all available the emergency generator, did not document the required mergency generator.	K 1	44		



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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

PRINTED: 05/13/2016

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING _ 00655 04/21/2016 STREET ADDRESS CITY STATE 7IP CODE NAME OF BROVIDED OR SLIBBLIED

	PROVIDER OR SUPPLIER ON MUNICIPAL HOSPITAL	30 SOUTH	BEHL STRE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENC (EACH DEFICIENCY MUST BE PRECEDED REGULATORY OR LSC IDENTIFYING INFOR	CIES BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
2 000	Initial Comments		2 000		
	*****ATTENTION*****				
	NH LICENSING CORRECTION OF	RDER			
	In accordance with Minnesota Statute 144A.10, this correction order has be pursuant to a survey. If, upon reinspe found that the deficiency or deficienciherein are not corrected, a fine for eanot corrected shall be assessed in ac with a schedule of fines promulgated the Minnesota Department of Health.	en issued ection, it is es cited ch violation cordance			
	Determination of whether a violation is corrected requires compliance with all requirements of the rule provided at the number and MN Rule number indicate. When a rule contains several items, if comply with any of the items will be collack of compliance. Lack of compliance re-inspection with any item of multi-paresult in the assessment of a fine ever that was violated during the initial inspector of the corrected.	I he tag ed below. ailure to onsidered ace upon art rule will n if the item			
	You may request a hearing on any as that may result from non-compliance orders provided that a written request the Department within 15 days of recentice of assessment for non-compliance.	with these is made to eipt of a			
	INITIAL COMMENTS: You have agreed to participate in the receipt of State licensure orders cons the Minnesota Department of Health Informational Bulletin 14-01, available http://www.health.state.mn.us/divs/fpcobul.htm The State licensing orders	e at c/profinfo/inf			

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

delineated on the attached Minnesota

Electronically Signed 05/13/16

STATE FORM 6899 If continuation sheet 1 of 4 1PTN11

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00655	B. WING		04/2	21/2016
APPLETON MUNICIPAL HOSPITAL 30 SOUTH			DRESS, CITY, S H BEHL STR DN, MN 5620			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Department of Hear you electronically. Is necessary for State enter the word "corn text. You must then State licensure proceed completion date, the corrected prior to el Minnesota Department on April 18, 19, 20, Department's staff, the following correct Please indicate in y correction that you and identify the date Minnesota Department the State Licensing federal software. The assigned to Minnesota Nursing Homes. The assigned tag in column entitled "ID statute/rule out of commany Statement and replaces the "Torrection order. The findings which are in after the statement, evidence by." Followare the Suggested Time period for Corplease State of the Suggested Time period for Corplease State of Torrection order. The Suggested Time period for Corplease State of Time Period for Co	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be ectronically submitting to the ment of Health. 21 of 2016, surveyors of this visited the above provider and tion orders are issued. Our electronic plan of have reviewed these orders, when they will be completed. The ent of Health is documenting Correction Orders using an umbers have been ota state statutes/rules for umber appears in the far left Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the sis column also includes the n violation of the state statute. "This Rule is not met as wing the surveyors findings Method of Correction and rection. IRD THE HEADING OF THE	2 000			
	FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.					

Minnesota Department of Health STATE FORM

1PTN11 If continuation sheet 2 of 4

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND DUAN OF CORDECTION IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BOILDING.			
00655		B. WING		04/2	21/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSE	ΡΙΤΔΙ	I BEHL STR N, MN 5620			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			5/26/16
	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.					
	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.			Corrected.		
	was seated in the recatheter bag was ly The catheter tubing R11's right pant leg tubing, and the cath urine. R11 stated sthe nursing assistant	on 4/18/16, at 1:57 p.m. R11 ecliner in her room and the ring on the floor uncovered. I was observed coming out of and urine was present in the neter bag was about half full of the was embarrassed when the roots did not cover the drainage because others were able to				

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00655	B. WING		04/2	1/2016
APPLETON MUNICIPAL HOSPITAL 30 SOUTH			DRESS, CITY, S H BEHL STR DN, MN 5620		•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	see the urinary cather During an interview nursing assistant (Not bag should be covered to the covered so it is not be covering visible to others. A policy regarding of to the catheter bag provided. SUGGESTED MET The director of nursiand revise policies dignity and provision education on provided director of nursing of audit tool to ensure provided.		21805			

Minnesota Department of Health STATE FORM

TE FORM 1PTN11 If continuation sheet 4 of 4

PRINTED: 05/05/2016 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '		(X3) DATE SURVEY COMPLETED	
		A. Bolletino.			
00655			B. WING		04/21/2016
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA		
APPLETO	N MUNICIPAL HOSPITAL		BEHL STREET N, MN 56208		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
2 000	Initial Comments		2 000		
	****ATTEN	TION*****			
	NH LICENSING CO	ORRECTION ORDER			
	144A.10, this correcting pursuant to a survey. found that the deficier herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart. Determination of where corrected requires corrected requires correquirements of the runumber and MN Rule. When a rule contains comply with any of the lack of compliance. Line-inspection with any result in the assessments.	ther a violation has been mpliance with all			
	that may result from norders provided that a	earing on any assessments con-compliance with these a written request is made to a 15 days of receipt of a for non-compliance.			
	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 http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm The State licensing orders are delineated on the attached Minnesota				

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

(X6) DATE TITLE

A. BUILDING:	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Υ
2 1/1/2			
00655 B. WING 04/21/2016		04/21/201	16
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	NAME OF PROVIDER OR SUPPLIER		
APPLETON MUNICIPAL HOSPITAL 30 SOUTH BEHL STREET	APPLETON MUNICIPAL HOSPITA		
APPLETON, MN 56208	OLIMANA DV OZ		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	PREFIX (EACH DEFICIENC	D BE COM	(X5) DMPLETE DATE
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. 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. 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 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	Department of Health you electronically. A is necessary for State enter the word "corretext. You must then in State licensure procecompletion date, the corrected prior to ele Minnesota Department's staff, vothe following correction that you have and identify the date. Minnesota Department the State Licensing of federal software. Tagassigned to Minnesota Nursing Homes. The assigned tag nurcolumn entitled "ID Festatute/rule out of correction order. This findings which are in after the statement," evidence by." Following are the Suggested Minnesota Departmental the Statement, "evidence by." Following ware the Suggested Minnesota Departmental the Statement, "evidence by." Following ware the Suggested Minnesota Departmental the Statement, "evidence by." Following are the Suggested Minnesota Departmental the Suggested		

Minnesota Department of Health

STATE FORM 6899 1PTN11 If continuation sheet 2 of 4

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
			B. WING		
		00655	B. WING		04/21/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	
APPLETO	N MUNICIPAL HOSPITAL		H BEHL STREET		
		APPLET	ON, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
2 000	Continued From page	2	2 000		
	· ·	IREMENT TO SUBMIT A ION FOR VIOLATIONS OF STATUTES/RULES.			
21805	MN St. Statute 144.68 Residents of HC Fac.		21805		
	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.				
	by: Based on observation review the facility faile maintained for 1 of 1 urinary catheter bag vother residents, visito at the facility. Findings include: R11's quarterly Minim 3/22/16, indicated the impairment, required dressing, toileting, pe	t is not met as evidenced a, interview, and document ed to ensure dignity was residents (R11) whose vas uncovered and visible to rs, and/ or family members um Data Set (MDS) dated resident had no cognitive extensive assistance with rsonal hygiene, and was king on and off the unit.			
	was seated in the rec catheter bag was lying. The catheter tubing w R11's right pant leg, a tubing, and the cathet urine. R11 stated she the nursing assistants	in 4/18/16, at 1:57 p.m. R11 liner in her room and the g on the floor uncovered. as observed coming out of and urine was present in the arer bag was about half full of e was embarrassed when a did not cover the drainage ecause others were able to			

Minnesota Department of Health

STATE FORM 6899 1PTN11 If continuation sheet 3 of 4

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
00655		B. WING		04/21/2016			
NAME OF P	ROVIDER OR SUPPLIER			TE ZIP CODE	1 04/21/2016		
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 30 SOUTH BEHL STREET						
APPLETO	N MUNICIPAL HOSPITAL	APPLETON	N, 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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE		
21805	Continued From page 3		21805				
	see the urinary cather	ter and urine.					
	nursing assistant (NA	n 4/20/16, at 8:11 a.m.)-A stated R11's catheter d at all times so it is not					
	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.						
		/20/16, at 11:07 a.m. se (LPN)-B verified staff 11's catheter bag so it is not					
	A policy regarding dignity and/ or applying a cover to the catheter bag was requested but not provided.						
	The director of nursin and revise policies and dignity and provision education on providin director of nursing or audit tool to ensure diprovided.	OD OF CORRECTION: g, or designee, could review and procedures related to of care, and provide staff g dignified care. The designee could develop an ignified resident care is CORRECTION: Twenty-one					

Minnesota Department of Health

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