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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HB61

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00655

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/12/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)
13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 09/12/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 09/12/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/10/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245231

September 12, 2018

Administrator
Appleton Municipal Hospital
30 South Behl Street
Appleton, MN 56208

Dear Administrator:

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

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

Effective September 4, 2018 the above facility is recommended for:

50 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 12, 2018

Administrator
Appleton Municipal Hospital
30 South Behl Street
Appleton, MN 56208

RE: Project Number S5231028

Dear Administrator:

On August 13, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 26, 2018. 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 September 12, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 5, 2018 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 July 26, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 4, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 26, 2018, effective September 4, 2018 and therefore remedies outlined in our letter to you dated August 13, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HB61

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00655

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/12/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
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FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)
13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 09/12/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 09/12/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/10/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245231

September 12, 2018

Administrator
Appleton Municipal Hospital
30 South Behl Street
Appleton, MN 56208

Dear Administrator:

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

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

Effective September 4, 2018 the above facility is recommended for:

50 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 12, 2018

Administrator
Appleton Municipal Hospital
30 South Behl Street
Appleton, MN 56208

RE: Project Number S5231028

Dear Administrator:

On August 13, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 26, 2018. 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 September 12, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 5, 2018 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 July 26, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 4, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 26, 2018, effective September 4, 2018 and therefore remedies outlined in our letter to you dated August 13, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
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DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HB61

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Facility ID: 00655

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(L3) **APPLETON MUNICIPAL HOSPITAL**
(L4) **30 SOUTH BEHL STREET**
(L5) **APPLETON, MN** (L6) **56208**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/26/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
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04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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From (a) :
To (b) :

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Jonathan Anderson, HFE - NE II 08/31/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 09/07/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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08/01/1982
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24. LTC AGREEMENT ENDING DATE
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25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 13, 2018

Ms. Lori Andreas, Administrator
Appleton Municipal Hospital
30 South Behl Street
Appleton, MN 56208

RE: Project Number S5231028

Dear Ms. Andreas:

On July 26, 2018, 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.

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 an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 4, 2018, 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 September 4, 2018 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 October 26, 2018 (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 January 26, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245231	A. BUILDING _____ B. WING _____	07/26/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on July 23, through July 26, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On July 23, through July 26, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		9/4/18

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

Electronically Signed | 08/23/2018

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

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F 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide services in a dignified manner for 1 of 2 residents (R30) who utilized a Foley catheter.	F 550	1) Resident R30 now has a dignity bag in place and is noted in the care plan. Resident R30's catheter bag will be monitored for proper catheter care/bag	

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F 550	Continued From page 2 Finding include: R30's quarterly Minimum Data Set (MDS) dated 6/12/18, indicated R30 was cognitively intact, and had diagnoses which included neurogenic bladder, bladder disorder, and diabetes. The MDS also indicated R30 required extensive assistance of one staff for dressing, toilet use, personal hygiene, and limited assistance of one for bed mobility and transfers. MDS also indicated R30 required the use of an indwelling catheter. R30's care plan revised on 6/27/18, indicated R30 was at risk for infection related to age, chronic disease (renal diseases, congestive heart failure), community living setting, diabetes mellitus, and indwelling/intermittent catheterization. Further review of R30's care plan indicated R30 had an indwelling catheter related to flaccid bladder. The care plan directed staff to provide catheter care twice daily, position catheter bag and tubing below the level of the bladder, away from the entrance of the door, and when up, R30 likes the catheter tubing going down left leg. During observations on 7/23/18, at 2:13 p.m. R30 was in her room seated in a brown recliner. R30's catheter tubing ran directly down her left leg all the way to the floor, where the catheter drainage bag was observed lying directly on the tile flooring face down and was uncovered. R30's catheter tubing and drainage bag had bright yellow urine noted. R30 indicated she did not like her catheter bag uncovered and lying on the floor when she had company in her room and stated, "I wish they could cover it with something."	F 550	handling. 2) All residents with catheters were identified and also were verified to have dignity bags covering their drainage bags. All residents with catheter bags will be monitored during cares for proper catheter care/bag handling. 3) Policy/procedure have been reviewed/revised regarding catheter cares/handling and will be shared with staff at an education session on September 4th, 2018. In addition, staff received education regarding all of the areas of concern listed by state surveyors at an educational session on August 1st, 2018. 4)Audits on R30's dignity bag placement will be completed by DON 3 times weekly for 4 weeks. Results will then be reported to QA to determine how frequently following that 4 week period. Audits will also be completed by DON 3 times weekly on random residents with indwelling catheters to check for dignity bag placement for 4 weeks. Those results will also be reported to QA to determine next appropriate steps. R30's catheter cares/bag handling will be audited 3x weekly for 4 weeks and the results will be brought to QA. Random audits of catheter care/bag handling will be completed 3x weekly for 4 weeks on random residents with indwelling catheters.	

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F 550	Continued From page 3 During observation on 7/24/18, at 10:40 a.m. R30 was seated in her recliner in her room. R30's catheter tubing ran directly down her left leg all the way to the floor, where the catheter drainage bag was observed lying directly on the tile flooring face down and was uncovered. R30's catheter tubing and drainage bag had bright yellow urine in it. -at 2:10 p.m. R30 was seated in her recliner in her room with her feet up on the foot rest of her recliner sleeping. R30's catheter tubing ran directly down her left leg all the way down to the catheter drainage bag which was observed lying directly in a gray basin, which was setting on the floor directly out in front of R30's recliner, and was uncovered. R30's catheter tubing and drainage bag had bright yellow urine in it. During observations on 7/25/18, at 7:29 a.m. R30 was lying in bed with head of bed elevated slightly, and was working on her computer. R30's catheter tubing ran directly down the right side of her bed all the way down to the catheter drainage bag which was observed lying directly in a gray basin, which was setting on the floor directly out on the side of R30's bed and was uncovered. R30's catheter tubing and drainage bag had bright yellow urine in it. During observations on 7/26/18, at 1:50 p.m. R30 was seated in her recliner in her room sleeping. R30's catheter tubing ran directly down her left leg all the way to the floor, where the catheter drainage bag was observed lying directly on the tile flooring face down, and was uncovered. R30's catheter tubing and drainage bag had bright yellow urine in it. -at 1:52 registered nurse (RN)-A entered R30's room and observed R30's catheter drainage bag	F 550		

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F 550	Continued From page 4	F 550		

lying directly on the tile flooring face down and uncovered. R30's catheter tubing and drainage bag had bright yellow urine in it. RN-A reached for R30's catheter bag, picked it up, and hung it on the side of R30's recliner. RN-A confirmed finding and verified R30 needed assistance from staff with all catheter cares and activities of daily living (ADLs). RN-A indicated R30's catheter drainage bag should not be lying directly on the floor, and should have something around it to protect it like a barrier. RN-A stated this was an infection control issue and dignity issue. RN-A indicated normally when residents are in their rooms, staff will use a pillow case to cover the catheter drainage bags.

On 7/25/18, at 9:38 a.m. R30 verified when she's in her room, staff will just let her catheter drainage bag lay on the floor full sometimes, and not cover it. R30 indicated it was embarrassing when she has had company in her room, when the bag is just laying on the floor or hung on the garbage can.

On 7/26/18, at 9:35 a.m. trained medication aid (TMA)-A confirmed catheter drainage bags should not be directly on the floor, but should be covered for dignity.

On 7/26/18, at 4:23 p.m. the director of nursing (DON) confirmed R30 needed staff assistance with ADLs, utilized the use of an indwelling catheter, and needed assistance with catheter cares. DON verified catheter drainage bags need to be covered if going on a surface (such as the floor) due to infection control issues. The DON also confirmed staff should be covering the catheter bags for dignity issues in case she has visitors. The DON indicated his expectations of

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F 550	Continued From page 5 staff would be to have them cover the catheter drainage bags. Review of facility policy titled Quality of Life Dignity revised on 7/2018, indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality.	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the	F 578		9/4/18

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F 578	Continued From page 6 time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident current wishes for resuscitation status were accurately documented in the clinical record for 1 of 2 residents (R35) reviewed for advanced directives. Findings include: R35's admission Minimum Data Set (MDS) dated 12/27/17, indicated R35 had intact cognition, and diagnoses which included dementia, atrial fibrillation, chronic obstructive pulmonary disease, and history of pulmonary embolism. Review of R35's Health Care Directive (HCD) dated 12/5/06, indicated no certain code status for R35. However, R35's HCD had Terminal Condition Instructions, that were to be used only if R35 had a terminal condition and was unable to express her wishes. In the event of a terminal condition, R35 wished to be allowed to die naturally and not be kept alive by artificial means or heroic measures. Review of R35's physician signed Care Center	F 578	1) Resident R35 was met with and determined her wish to be full code. A red heart was placed on the spine of her medical record the day that it was brought to attention. Order from provider for full code has also been received and documented. 2) All resident's physician orders will be reviewed and compared to their care plan to ensure both DNR and DNI match resident wishes. All resident's charts will also be reviewed to ensure that the orders in the chart match the resident wishes. 3) Policy to be reviewed/revised and gone over with staff at September 4th, 2018 educational session in addition to the education provided on August 1st, 2018 regarding the areas of concern as listed by state surveyors. The updated policy will reflect that Social Services will meet with the new admit on admission and review code status with the resident and ensure resident wishes match physician	

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F 578	Continued From page 7 Transfer Form dated 12/21/17, indicated R35 wished to have a Do Not Resuscitate (DNR) order. Review of R35's Order Summary Report signed 7/2/18, lacked an order for R35's code status. Review of R35's care plan revised on 7/17/18, indicated on page one, under the header Special Instructions, "Full Code [to resuscitate] 12/21/17". R35's clinical record did not accurately reflect R35's current wishes for advance directives. On 7/26/18, at 9:29 a.m. trained medication aid (TMA)-A stated to determine a resident's code status, staff would look on the spine of that resident's hard chart for a sticker of a heart. If the resident's chart spine lacked a sticker, they would be considered a DNR. On 7/26/18, at 9:40 a.m. registered nurse (RN)-A stated a resident's code status would be determined by checking the spine of the hard chart for a red heart sticker. If the chart lacked the heart sticker, then there would be a sticker on the inside cover of the chart indicating DNR. RN-A reviewed the spine of R35's hard chart and confirmed R35's chart lacked the sticker. She then opened R35's chart and the sticker on the inside cover indicated "Advanced Directive." RN-A reviewed R35's HCD and indicated it was vague and only stated R35's wishes if she was terminal. RN-A confirmed R35 was not terminal and confirmed the above findings. On 7/26/18, at 9:55 a.m. director of nursing (DON) stated any resident admitted to the facility	F 578	orders. Social Service designee reviews code status with residents every 3 months and will ensure that the resident wishes continue to match physician orders. If a resident changes their wishes, a new physicians order will be completed to reflect those wishes. 4) Assess all new admissions for records for accuracy and consistency regarding code status for 3 months. Results to be reported to QA to determine further action needed at that time. Social Services to meet with all resident's to review advanced directives wishes to ensure physician orders match their wishes.	

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F 578	Continued From page 8	F 578		

with a HCD, would meet with the social services designee (SSD) and review their wishes for code status. DON reviewed R35's electronic health record and clinical chart and confirmed the above findings.

At 12:00 p.m. during a follow up interview with the DON, he stated the SSD, or her replacement, would be the person to place the red, heart sticker on the spine of the chart, if the resident had wished to have cardiopulmonary resuscitation (CPR). The DON indicated that there was no form filled out by residents that choose CPR, and the heart sticker was the indicator that staff would look for to represent the resident's wishes. The DON stated, "This one was missed."

At 7/26/18, at 3:48 p.m. during a phone interview with the SSD, she stated upon admission she reviewed R35's HCD with her and at that time she wished to have CPR. SSD stated when a resident wishes to have CPR a red, heart sticker would be placed on the spine of the hard chart by the charge nurse on admission which indicated the residents' wishes.

Review of the facility policy titled Advanced Directives approved 7/18, indicated "D. All advance directive document copies will be obtained and located (identify the same section of the resident's medical record that would be readily retrievable by any facility staff)." "E. Resident wishes will be communicated to the staff via the care plan and (identify facility protocol for communication of advance directives either in written or oral format) and to the resident physician."

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F 580	Continued From page 9	F 580		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and	F 580		9/4/18

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F 580	Continued From page 10 phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the responsible party and physician were notified timely of a alteration in skin integrity for 1 of 1 resident (R25) reviewed for notification of change. Findings include: R25's admission Minimum Data Set (MDS) dated 8/30/17, identified R25 had severe cognitive impairment, and had diagnoses which included dementia, arthritis, depression, and impaired vision. The MDS further identified R25 was not able to walk, required extensive staff assistance with all areas of daily living with the exception of the ability to eat with staff supervision. R25's Admission Record printed 7/25/18, identified R25's family member (FM)-A as R25's responsible party, care conference person, and primary emergency contact #1. On 7/23/18, at 6:39 p.m. during interview, family member (FM)-A identified a concern of poor communication by facility staff in regards to R25's health care and appointments.	F 580	1) Medical director and DON will review policy and procedure and update accordingly. R25's family was notified of the skin tear on the day of finding that it had not been communicated. Resident R25's incident reports will be reviewed from the last quarter and family and MD will be notified of any incidents that have not been documented to have been communicated to them. 2) Review all residents chart from the last 30 days to identify all notifiable instances. If there are any notifiable instances, according to policy, that occurred and the appropriate parties (MD and family) were not notified, staff will notify the appropriate parties at the time of finding. Will continue to monitor future notifiable incidents for 2 additional months. 3) Review policy/procedure with staff and educate staff on September 4th, 2018 at educational meeting. In addition, staff	

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F 580	Continued From page 11 On 7/25/18, at 7:20 a.m. during observation of provision of morning cares, R25's sheets were noted to have several areas with yellow and tan colored stains, and several spots of what appeared to be dried blood near R25's left elbow. R25's left elbow was noted to have an oval shaped sore approximately 1.5 centimeter (cm) x 1 cm, with the surrounding skin red in color, and extending out from the open area approximately 1 cm. R25's progress notes were reviewed and identified the following entries: -6/28/18. Skin/Wound note: Skin assessment completed with a.m. bath noted bruising to left posterior above elbow measuring 3 x 3.5 x 0 cm. Noted band-aid covering bruising to left posterior lateral side below elbow measuring 4.5 x 2 x 0 cm with intact scabbed skin tear measuring 0.3 x 0.1 x 0, no warmth or redness noted to scabbed area or bruising. R25's record lacked further documentation regarding the skin tear or bruising of the left elbow. The electronic treatment record lacked documentation of the skin tear and bruising or any needed treatments on the left elbow. On 7/25/18, at 8:52 a.m. registered nurse (RN)-A indicated the usual facility protocol for an identified alteration in skin as follows: A skin form is completed in the computer system which triggers a weekly follow up by nursing. The residents physician and family are notified of the skin condition, and if necessary a wound nurse is	F 580	received education regarding notification of changes on August 1st, 2018 at nursing meeting that discussed the areas of concern as stated by state surveyors. 4) MDS coordinators will audit all changes in condition that require family and MD notification from the last 30 days for all residents. All changes that require MD and family notification will be audited for 2 months and reported to QA to ensure the deficiency does not recur. Further action will be determined by QA committee following data collection period to determine if further monitoring is required.	

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F 580	Continued From page 12	F 580		

notified. RN-A reviewed R25's electronic record, and verified the progress noted dated 6/28/18, which identified R25's skin tear and bruising on the left elbow. RN-A further reviewed R25's medical record and verified no further documentation was found.

On 7/25/18, at 9:06 a.m. R25's elbow was visualized by RN-A. RN-A verified R25 had a wound on the left elbow which measured 1.3 x 0.7 cm. RN-A stated, "Someone dropped the ball here."

On 7/25/18, at 2:51 p.m. the director of nursing (DON) indicated the the usual facility protocol with a change in condition or skin alteration as follows:
1st- Complete an incident form and skin form. Clean and dress the area appropriately.
2nd- Notify the family and the physician.
The DON clarified with the skin form initiated the computer system then has pop-ups weekly to alert the floor nurses to ensure the area is reviewed weekly by licensed staff.

The facility policy titled Skin Tears-Abrasions and Minor Breaks, Care of, revised 7/2017, directed under the subtitle Reporting: Notify the responsible family member. Physician notification may be routine (that is, non-immediate) if the abrasion is uncomplicated or not associated with significant trauma.

The facility policy titled Notification of Changes, revised 7/2017, identified directed changes in a resident's condition or treatment are immediately shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate. The resident and/or their representative will be

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F 580	Continued From page 13 educated about treatment options and supported to make an informed choice about care preferences when there are multiple care options available. All pertinent information will be made available to the provider by the facility staff.	F 580		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide grooming and oral hygiene assistance for 1 of 3 residents (R25) who required assistance from staff to complete activities of daily living. Findings include: R25's annual Minimum Data Set (MDS) dated 8/30/17, identified R25 had diagnoses which included dementia, arthritis, depression, and impaired vision. The MDS further identified R25 had severe cognitive impairment,was not able to walk, and required extensive staff assistance with all areas of daily living. R25's care plan revised 9/13/17, identified R25 had dementia, upper dentures and his own lower teeth, and required extensive staff assistance with personal hygiene and oral cares. The care plan identified R25 required oral inspection QD (every day) with oral cares and PRN (as needed), On 7/23/18, at 6:27 p.m. family member (FM)-A	F 677	1) Review oral care and personal hygiene as it relates to shaving plan of care with family and staff and update care plan accordingly to ensure staff knows the appropriate way to care for R25 as it relates to oral cares and personal hygiene (shaving). 2) Reviewing/assessing oral cares and personal hygiene as it relates to shaving for all other residents will be completed (see audits). 3) Policy to be reviewed with staff at September 4th, 2018 educational meeting in addition to the education received on August 1st, 2018 related to the areas of concern as stated by state surveyors upon exit interview. Education will include the appropriate way to complete oral cares and personal hygiene cares which include shaving all residents with facial hair, depending on resident preference.	9/4/18

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F 677	Continued From page 14 stated facility staff did not provide R25 daily assistance to shave his face and brush his lower teeth. FM-A stated R25 had shaved daily at home, and liked to be clean shaven. FM-A further indicated R25's breath had been foul in the past and staff were alerted to brush his teeth, however; oral cares continued to not be completed daily. On 7/25/18, at 7:20 a.m. nursing assistant (NA)-C was present in R25's room providing assistance with morning cares. NA-C obtained R25's upper denture from the bathroom, rinsed them with water and placed them in R25's mouth. NA-C then began to organize the room, gather the linens, and garbage. R25 had facial stubble/hair present on his face. NA-C did not offer to shave R25 nor was oral care offered for R25's lower teeth. On 7/25/18, at 7:46 a.m. NA-C verified R25's morning cares were provided as usual. NA-C indicated shaving for R25 was provided as needed. NA-C stated she had not shaved R25 because she felt he did not have enough stubble on his face to require shaving assistance. NA-C indicated R25's dentures were brushed at night and mouth rinsed with a mouth wash, however; R25's teeth were not brushed. Observation of R25's bathroom and above the sink cabinet was conducted with NA-C, NA-C was able to locate denture products and mouthwash. R25's bathroom supplies did not include a tooth brush or tooth paste. On 7/25/18, at 10:06 a.m. the director of nursing (DON) indicated FM-A was very involved with R25's care and would know his choices. The DON indicated she felt the facility honored	F 677	4) Audits to be completed for R25's oral cares to be completed 4 times weekly for four weeks to be completed by floor nursing licensed staff with assistance from resident's wife who visits daily. R25 will have audits completed as they relate to personal hygiene and shaving 4x weekly for four weeks. Random resident's oral cares will be audited 3 times per week for 4 weeks to ensure they are completed according to care plan. Random residents personal hygiene as it relates to shaving will also be audited 3 times per week for four weeks to ensure the cares are being completed according to care plan to ensure that the process is sustained following the education. Results to be reported to QA and then determine appropriate action going forward.	

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F 677	Continued From page 15 resident and family choice of how often a male resident was shaved. The DON confirmed she expected staff provide assistance to shave and brush residents teeth for those who require assistance. The facility policy titled Teeth Brushing, revised 7/2018, The purposes of the procedure are to clean and freshen the resident's mouth, to prevent infections of the mouth, to maintain the teeth and gums in a healthy condition, to stimulate the gums, and to remove food particles from between the teeth.	F 677		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		9/4/18

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F 880	Continued From page 16 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 17 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate infection control measures were followed related to the care of catheter drainage bags for 2 of 2 residents (R3, R30) observed with an indwelling catheter. Findings include: R3's significant change Minimum Data Set (MDS) dated 4/3/18, indicated R3 was cognitively intact and had diagnoses which included benign prostatic hyperplasia (BPH), obstructive uropathy, and retention of urine. The MDS also indicated R3 required extensive assistance of one staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. R3's MDS further indicated the utilized an indwelling catheter. R3's care plan, last revised 7/17/18, indicated R3 was at risk for infection related to age, chair fast, community living setting, compromised skin integrity, Diabetes Mellitus, and occasionally incontinent of bladder. R3's care plan further revealed a history of urinary tract infections (UTI), and the use of an indwelling catheter related to BPH, urinary retention, and prostate cancer. The care plan directed staff to complete catheter care twice daily, use catheter secure to decrease risk of trauma, position catheter bag below level of bladder and cover catheter collection bag with catheter cover at all times for dignity. On 7/25/18, at 7:14 a.m. R3 lay in bed on his	F 880	1) Resident R30 and R3 now have a dignity bag in place and have their catheter free floating and not touching the ground. R30 and R3 will be monitored to ensure that staff are properly handling catheter bag during cares. 2) All residents with catheters were identified and also were verified to have dignity bags covering their drainage bags which act as a buffer if the drainage bag were to touch the ground. All other residents catheter bags are currently free floating and not touching the ground. 3) Policy/procedure have been reviewed/revised and will be shared with staff at an education session on September 4th, 2018. In addition, staff received education regarding all of the areas of concern listed by state surveyors at an educational session on August 1st, 2018 instructing to never leave a drainage bag touching the floor directly. Education will include proper catheter cares, bag handling, and sanitization to ensure proper infection control protocol is being followed during catheter cares. 4)Audits on R30's and R3's dignity bag placement and location of drainage bag (not touching the floor) will be completed by DON 3 times weekly for 4 weeks. Audits will also be completed on R30 and	

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F 880	Continued From page 18 back with his eyes closed. His bed was in the lowest position, against a wall, and a maroon fall mat was on the floor next to the bed. A catheter tube was observed between the end of the R3's footboard and the wall. The catheter tubing was followed to the floor where a catheter drainage bag was observed lying flat on the floor with the side of the bag with the opening spout resting on the floor. No cover was observed on the bag. At 9:36 a.m. nursing assistant (NA)-A entered R3's room to assist him with morning cares. NA-A washed her hands and donned gloves, raised R3's bed and began washing R3's perineal area and catheter tubing. R3's catheter drainage bag remained lying flat on the floor with the side with the opening spout resting directly on the floor. At 9:49 a.m. NA-A stated R3 had a problem emptying his bladder and used a catheter. She went into R3's bathroom, obtained a plastic graduated cylinder, a paper towel, and an alcohol wipe and returned to R3's bed. NA-A placed the paper towel directly on the floor near R3's footboard and placed the plastic cylinder onto the paper towel. NA-A then reached over R3's legs and grabbed the catheter tubing near the footboard and pulled the catheter drainage bag off of the floor. As NA-A pulled up on the tubing, the light yellow urine with white fibrous sediment flowed back up the catheter tubing towards R3's body. NA-A confirmed the catheter drainage bag had laid directly on the floor on it's face and stated the catheter drainage bag was usually stored in a plastic basin on the floor. No plastic basin was noted in R3's room. NA-A then bent down next to the cylinder on the paper towel and opened the drainage bag spout and emptied the bag of it's urine, spilling two small areas approximately three inches in diameter of urine	F 880	R3's catheter cares to ensure proper infection control protocol is being followed 3 times weekly for four weeks. Results will then be reported to QA to determine how frequently following that 4 week period. Audits will also be completed by DON 3 times weekly on random residents with indwelling catheters to check for dignity bag placement and location of drainage bag for 4 weeks. Audits will also be conducted on random residents catheter cares 3x weekly for 4 weeks to ensure proper infection control protocol is being followed. These audits should ensure the problem is not recurring Those results will also be reported to QA to determine appropriate amount of audits to ensure the practice is sustained going forward.	

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F 880	Continued From page 19 onto the floor. NA-A wiped the drainage bag spout with an alcohol wipe, closed the spout and hung the catheter drainage bag on to the footboard using the attached plastic hook. NA-A then emptied the urine into the toilet, rinsed the cylinder and grabbed a cloth hand towel, soaked it in water and returned to the end of R3's bed. NA-A bent near the spilled areas of urine and wiped them up using the towel with water. NA-A placed the towel in a plastic garbage bag with other dirty linen, removed her gloves and washed her hands. At 10:08 a.m. NA-A left R3's room and returned with NA-B to assist her with transferring R3 to his power wheelchair. NA-B grabbed R3's catheter drainage bag off of the footboard and attached it to the mechanical stand for the transfer. While transferring the drainage bag multiple drops of urine fell from the drainage spout directly onto the floor. NA-A and NA-B then transferred R3 to his power wheelchair. NA-A took R3's drainage bag off of the mechanical lift and placed it directly onto R3's power wheelchair footrest. NA-B asked NA-A if R3 had a dignity bag (a bag used to conceal a urine drainage bag used for resident dignity purposes and also acts as a barrier for infection control purposes). NA-A stated R3 had one a long time ago and has not seen it in a while. NA-A and NA-B looked in R3's room for a dignity bag, but one was not found. NA-B left R3's room pushing out the mechanical stand. NA-A left R3's room leaving the catheter drainage bag lying directly on R3's power wheelchair footrest between his shoes. Neither NA-A or NA-B were observed to clean the multiple drops of urine on R3's floor. At 10:22 a.m. NA-A returned to R3's room with a black colored dignity bag and attached it to the base of R3's power wheelchair.	F 880		

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F 880	Continued From page 20 She then placed the drainage bag inside of the dignity bag. On 7/26/18, at 8:36 a.m. NA-A was in R3's room assisting him with morning cares. R3's catheter drainage bag laid directly on the floor near the foot end of the bed. NA-A looked at the drainage bag on the floor, picked it up, and placed it on the footboard using the attached plastic hook. NA-A stated the drainage bag was on the footboard prior and was moved due to R3 moving around in bed. A plastic basin for holding the drainage bag was not observed on the floor or in R3's room. On 7/26/18, at 9:35 a.m. trained medication aid (TMA)-A stated catheter drainage bags should never be directly on the floor due to infection control concerns. TMA-A indicated drainage bags should be hooked to the bed frame to keep them in place, but R3's bed was kept in the low position when occupied, so staff would use a plastic basin to place the drainage bag in to keep it off of the floor. On 7/26/18, at 10:31 a.m. registered nurse (RN)-A stated catheter drainage bags should never touch the floor due to infection control concerns. RN-A indicated R3's catheter drainage bag should be hung by the bed frame, but when his bed was lowered the drainage bag would touch the floor. RN-A stated that staff's normal practice was to use pillow cases to create a barrier between the catheter drainage bag and the floor. On 7/26/18, at 3:07 p.m. director of nursing (DON) stated R3 had a history of UTIs and was at risk for infection, and developing another UTI. DON stated catheter drainage bags should not be	F 880		

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F 880	Continued From page 21 directly on the floor due to infection control issues and contamination of the catheter drainage bag. R30 R30's quarterly MDS dated 6/12/18, indicated R30 was cognitively intact and had diagnoses which included neurogenic bladder, bladder disorder and diabetes. The MDS also indicated R30 required extensive assistance of one staff for dressing, toilet use, personal hygiene and limited assistance of one for bed mobility and transfers. MDS also indicated R30 required the use of an indwelling catheter. R30's care plan revised on 6/27/18, indicated R30 was at risk for infection related to age, chronic disease (renal diseases, congestive heart failure), community living setting, diabetes mellitus, indwelling/intermittent catheterization. R30's care plan indicated R30 had an indwelling catheter related to flaccid bladder. The care plan directed staff to provide catheter care twice daily, position catheter bag and tubing below the level of the bladder, away from entrance of door and when up likes catheter tubing going down left leg. During observations on 7/23/18 at 2:13 p.m. R30 was in her room seated in a brown recliner, R30's catheter tubing ran directly down her left leg all the way to the floor where the catheter drainage bag was observed lying directly on the tile flooring with the opening spout resting directly on the floor and was not covered. R30's catheter tubing and drainage bag had bright yellow urine noted. R30 indicated she did not like her catheter bag not covered and lying on the floor when she had	F 880		

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F 880	Continued From page 22 company in her room and stated "I wish they could cover it with something." During observation on 7/24/18 at 10:40 a.m. R30's was seating in her recliner in her room. R30's catheter tubing ran directly down her left leg all the way to the floor where the catheter drainage bag was observed lying directly on the tile flooring with the opening spout resting directly on the floor and was not covered. R30's catheter tubing and drainage bag had bright yellow urine in it. During observations on 7/26/18 at 1:50 p.m. R30 was seated in her recliner in her room sleeping. R30's catheter tubing ran directly down her left leg all the way to the floor where the catheter drainage bag was observed lying directly on the tile flooring, spout down and was not covered. R30's catheter tubing and drainage bag had bright yellow urine in it. -at 1:52 RN-A entered R30's room and observed R30's catheter drainage bag lying directly on the tile flooring face down and was not covered. R30's catheter tubing and drainage bag had bright yellow urine in it. RN-A reached for R30's catheter bag lying on the floor, picked it up and hung it on the side of R30's recliner. RN-A confirmed the above finding and verified R30 needed assistance from staff with all catheter cares and activities of daily living (ADL's). RN-A indicated R30's catheter drainage bag should not be lying directly on the floor and should have something around it to protect it like a barrier. RN-A stated this was an infection control issue and dignity. RN-A indicated that normally when residents are in their rooms, staff will use a pillow case to cover the catheter drainage bags.	F 880		

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F 880	Continued From page 23 On 7/25/18 at 9:38 a.m. R30 verified when she's in her room, staff will just let her catheter drainage bag rest on the floor full sometimes and not cover it. R30 indicated it was embarrassing when she has had company in her room and its just laying on the floor or hang her catheter bag on the garbage can. On 7/26/18 at 4:23 p.m. DON confirmed R30 needed staff assistance with ADL's, utilized the use of indwelling catheter and needed assistance with catheter cares. DON verified catheter drainage bags need to be covered if going on a surface due to infection control issues. The DON also confirmed staff should be covering the catheter bags for dignity issues as well in case she has visitors. The DON indicated his expectations of staff would be to have them cover the catheter drainage bags and indicated staff need to do a better job with this on skills day. Review of facility policy titled, Catheter Care Urinary revised on 7/2018, indicated the purpose of this procedure is to prevent catheter associated urinary tract infections. under infection control: use standard precautions when handling or manipulating the drainage system, maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag and be sure the catheter tubing and drainage bag are kept off the floor.	F 880		
F 943 SS=B	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12,	F 943		9/4/18

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F 943	Continued From page 24 facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required initial training on resident Alzheimer's disease and related training including dementia management for 5 of 5 employees (E2, E3, E4, E5, E6) reviewed for dementia care training. In addition, the facility failed to provide the required initial and annual training on resident abuse prevention for 1 of 5 employees (E1) reviewed for abuse/ vulnerable adult (VA) training. Findings include: The Appleton Area Health Services facility assessment dated 11/24/18, included the following: Services and Care we offer Based on our Residents' needs-Mental Health and behavior-Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of	F 943	1) Alzheimer's disease and related training to dementia management will be completed by employees E2, E3, E4, E5, and E6 by September 7th through Net Learning. Annual training on resident abuse prevention for E1 will be completed by September 7th with Social Service Designee. 2) HR will assess all employee records to ensure annual training regarding Alzheimer's disease and related training including dementia management by September 4th, 2018. Policy has been reviewed and updated to reflect that new hires will not be able to start working on the floor without having completed the Alzheimer's and dementia related training as well as the abuse/neglect training. 3) Process for annual training and new hire training has been reviewed and determined that new hire training regarding Alzheimer's disease and related	

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F 943	Continued From page 25 individuals with depression, trauma/PTSD (post traumatic stress disorder), other psychiatric diagnoses, intellectual or developmental disabilities. Further the assessment listed the boarding process trains our staff on each resident needs, the complexity of our residents is in their individual needs and abuse, neglect and exploitation. Activities that constitute abuse, neglect, exploitation and misappropriation of resident property, procedures for reporting incidents of abuse, neglect, exploitation and misappropriation of resident property and care/management for person with dementia and resident abuse prevention. On 7/25/18, the following employee education records were reviewed: - E2, hired as a dietary aid on 6/27/18. -E3, hired as a nursing assistant on 4/26/18. -E4, hired as a dietary aid on 5/30/18. -E5, hired as nursing assistant on 3/14/18. -E6, hired as a nursing assistant on 3/12/18. All five employee records lacked documentation dementia training had been completed. On 7/25/18, at 10:06 .am. the director of nursing (DON) identified the newly hired facility staff had not received training on care of residents with Alzheimer or dementia care. The DON identified the all staff yearly education was set to be completed next week and the new staff would receive the training at that time. The DON indicated new staff were not typically working without training for this length of time, however; identified the facility practice did not include completing the Alzheimer dementia training before working directly with residents.	F 943	training to dementia management (through Net Learning)and abuse prevention will be completed by all new hires prior to their first day on the floor. All employees will have completed annual training related to Alzheimer's disease and related training to dementia management and Abuse prevention each year. If it is not completed on a yearly basis signified by January 1st of the new year, staff will not be allowed to work on the floor until training has been completed. 4) HR will audit all new hire training completion before their start date (on the floor) 3 months and report results to QA. HR will continue to monitor all new hires and employees for both completion of new hire trainings as well as annual trainings as policy states to ensure the issue does not recur. Further action will be determined by QA committee. HR will also audit all current employees records to ensure yearly Alzheimer's disease and related training to dementia management has been completed for the last year signified by January 1st, 2017. Results will be reported to QA. HR will begin auditing employee records in December of 2018 to ensure this year's completion of annual training has been completed and follow up with those not in compliance. If not in compliance with annual by January 1st, 2019 employees will not be allowed to work on the floor until completing the training.	

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F 943	Continued From page 26 On 7/25/18, at 3:01 p.m. the administrator indicated being aware of the required training regarding Alzheimer's and dementia prior to working directly with patients. The administrator stated, "going forward we will have the training completed." On 7/26/18 at 12:25 p.m. review of employee records revealed the following: E1 was hired 1/17/18. E1's Net Learning transcript indicated E1 had not completed a VA training course since she was hired by the facility. On 7/26/18 at 4:18 p.m. director of nursing (DON) confirmed all new employees receive VA training upon hire and all other employees are trained annually. The DON verified all staff receive online training via Net Learning and verified E1 had not received VA training since she was hired on 1/17/18. The DON indicated with all the employee turn over human resources indicated the education fell through the cracks. The DON indicated the facility needed to monitor the education and to make sure the education was getting done. The DON indicated in the future they would be monitoring this and making sure the education has been given before staff work on the floor. Review of facility policy titled, Abuse, Neglect, Mistreatment and Misappropriation of Resident Property revised on 3/2017, indicated under training components: Abuse policy Requirements-it is the policy of this facility to train employees, through orientation and on-going	F 943		

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F 943	Continued From page 27 sessions on issues related to abuse and prohibition practices. Staff and volunteers will receive education about resident mistreatment, neglect, and abuse, including injuries of unknown source, exploitation and misappropriation of property upon first employment and annually after that.	F 943		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF 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 compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/23/2018

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Appleton Municipal Nursing Home is a 2-story building with a no 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. 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 40 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility had 1 of several exit corridors that did not meet the requirements of NFPA 101 "The Life Safety Code" 2012 edition, sections 7.1.10 and 19.2.1. This deficient practice could affect 15 of 50 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 1:00 p.m. to 4:00 p.m. on 07/23/2018, observations revealed that the floor decorations in the corridor next to rooms 236 and 238. This deficient conditions was confirmed by the Environmental Services Manager.	K 211	There have been floor decorations next to rooms 236 and 238 in the Care Center North corridor. Our Care Center DON will address this and make sure that these are removed by 9/1/2018. Our facility manager, CFO, and CNA will make sure this task is completed by 9/1/2018 and the DON will make sure there will be no more floor decorations in the future.	8/23/18
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in	K 293		8/23/18

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K 293	Continued From page 3 accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to properly identify an exterior door as required in The Life Safety Code NFPA 101 2012 edition section 7.10.8.3. This deficient condition could affect the exiting of 5 of the 50 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 1:00 pm to 4:00 pm on 07/23/2018 observations and staff interview revealed two Exit Signs that were not illuminated in the lower level rehab. This deficient conditions was confirmed by the Environmental Services Manager.	K 293	Two Exit Signs on the lower level rehab were not illuminated. Our facility manager will make sure that this issue is fixed and the Exit Signs are properly working by 9/1/2018. The CFO and CNO will review with facility manager to ensure this task is completed by 9/1/2018.	
K 311 SS=E	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire	K 311		8/23/18

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K 311	Continued From page 4 resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the stairshaft in accordance NFPA 101 (2012 edition) 7.1.1. This deficient practice could affect the exiting of all residents, staff and an undetermined amount of visitors in the kitchen area. Finding Include: On the facility tour between 1:00 pm to 4:00 pm on 07/23/2018 observations and staff interview revealed items stored in the stair well near the kitchen stairwell. This deficient condition was confirmed by the Environmental Services Supervisor.	K 311	The stairwell had items stored in it. The facility manager will make sure that these items are moved by 9/1/2018. The facility manager will also continue to observe this location to make sure nothing is stored in the stairwell in the future. The CFO and CNO will review with facility manager to ensure this task is completed by 9/1/2018.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.	K 321		8/23/18

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K 321	Continued From page 5 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain one hazardous storage room and one combustible storage room in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect the quick and efficient exiting for 11 of the 50 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 1:00 pm to 4:00 pm on 07/23/2018 observations and staff interview revealed the Oxygen room in the west corridor was not properly separated and no longer smoke resistant and did not have a closer. This deficient condition was confirmed by the Environmental Services Supervisor.	K 321	The oxygen room in the west corridor is no longer smoke resistant and also does not have a closer. The facility manager will make sure a proper door and closer is installed by 10/1/2018. The CFO and CNO will review with facility manager to ensure this task is completed by 10/1/2018.	
K 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101	K 341		8/23/18

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K 341	Continued From page 6 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (2012) section 19.3.4.1, 9.6.1.3 and NFPA 72 National Fire Alarm Code (2010) section 17.7.4.1. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect 5 of the 50 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 1:00 pm to 4:00 pm on 07/23/2018 observations and staff interview revealed a smoke detector with 36 inches of an HVAC diffuser in the lower level rehab.	K 341	The smoke detector when installed was placed to close to the HVAC vent in the lower level rehab. Our facility manager will relocate this smoke detector by 9/1/2018. The CFO and CNO will review with facility manager to ensure this task is completed by 9/1/2018.	

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	245231	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/25/2018**

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APPLETON MUNICIPAL HOSPITAL	**30 SOUTH BEHL STREET APPLETON, MN 56208**

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K 341	Continued From page 7 This deficient condition was confirmed by the Environmental Services Supervisor.	K 341		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect an undetermined amount of residents, staff and visitors. Findings include:	K 353	The sprinkler heads in the dining room were covered in lint and there is a hole in the ceiling in the lower level by the electrical room. The facility manager will review proper cleaning schedule with housekeeping to make sure sprinkler heads are clean. Facility manager will also make sure the ceiling tile is replaced by 9/1/2018. The CFO and CNO will review with facility manager to ensure this task is completed by 9/1/2018.	8/23/18

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K 353	Continued From page 8 On the facility tour between 1:00 pm to 4:00 pm on 07/23/2018 observations and staff interview revealed 4 sprinkler heads covered in lint in the dining room and a hole in the ceiling tile in the lower level corridor across from the electrical room. This deficient condition was confirmed by the Environmental Services Supervisor.	K 353		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other	K 363		8/23/18

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K 363	Continued From page 9 materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide two corridor doors with a means suitable for keeping the door closed and resist the passage of smoke in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.6.3.1 & 19.3.6.3.5. This deficient practice could allow for smoke to enter the corridor making it difficult to exit in the case of fire, affecting 24 of the 50 residents and an undetermined amount of staff and visitors. Findings include: On facility tour between 1:00 p.m. to 4:00 p.m. on 07/23/2018, it was observed that the door to the kitchen corridor was damaged and would not resist the passage of smoke and voids the fire rating. This deficient condition was verified by a Environmental Services Supervisor.	K 363	The current door in the kitchen corridor is damaged and needs to be replaced with a proper door. The facility manager will make sure that a new door is ordered and installed by 10/1/2018. The CFO and CNO will review with facility manager to ensure this task is completed by 10/1/2018.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101	K 372		8/23/18

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K 372	Continued From page 10 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain smoke dampers in accordance with The Standard for Fire Doors and Other Opening Protective's, NFPA 80 , 2010 edition section 19.4.1.1. This deficient practice could allow smoke to travel throughout smoke compartments affecting the exiting capabilities of all residents and an undetermined amount of staff and visitors. Findings include: On facility tour between 1:00 p.m. to 4:00 p.m. on 07/23/2018, observations revealed the smoke barrier by the time clock area, east wall was not sealed at the ceiling. This deficient condition was confirmed by the Environmental Services Supervisor.	K 372	The smoke barrier by the time clock area is not sealed at the ceiling. The additional needed 2 5/8" sheet rock will be extended to the roof deck along the fire barrier by 10/1/2018. Our facility manager along with the CFO and CNO will monitor this progress and ensure completion by 10/1/2018.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101	K 712		8/23/18

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K 712	Continued From page 11 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide documentation of fire drills at least quarterly on each shift as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all residents and an undetermined amount of staff and visitors. Findings include: On facility tour between 1:00 pm and 4:00 pm on 07/23/2018, documentation reviewed revealed Fire drills were not performed during these times: 1) 1st quarter 2nd and 3rd shift of 2018 2) 2nd shift second quarter in 2018 3) 3rd shift third quarter 2017 4) 1st and 2nd shift 4th quarter of 2017 This deficient practice was verified by the Environmental Services Supervisor.	K 712	Our facility manager was not present during the cited fire drills and did not log these events properly. Facility manager will be present for all required fire drills and document appropriately for each shift each quarter. Our facility manager along with the CFO and CNO will monitor this progress and ensure completion 9/1/2018.	

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K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. The deficient practice could affect all residents, visitors and staff. Findings include: On the facility tour between 1:00 pm to 4:00 pm on 07/23/2018 , documentation review and staff interview revealed the required risk assessment NFPA 99 had not been started at the time of the survey. This deficient conditions was confirmed by the Environmental Services Manager.	K 901	The facility had not started the risk assessment from NFPA 99 by the date of this inspection. The facility manager will start this immediately and this will be completed by 10/1/2018. Our facility manager along with the CFO and CNO will monitor this progress and ensure completion by 10/1/2018.	8/23/18
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing	K 914		8/23/18

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K 914	Continued From page 13 Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the electrical testing and maintenance was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.4. This could negatively affect 50 of 50 residents as well as an undetermined number of staff, and visitors to the facility. 6.3.2.2.6.2 (F), 6.3.2.4.2 (NFPA 99). Findings include: During documentation review between 1:00 pm to 4:00 pm on 07/23/2018, documentation could not be located to show that an electrical outlet inspection had occurred throughout the facility.	K 914	Our facility manager failed to produce documentation of our annual electrical outlet inspection. Our facility manager will ensure that this inspection is done annually and proper documentation is completed. We will complete this by 10/1/2018. Our facility manager along with the CFO and CNO will monitor this progress and ensure completion by following up with the facility manager and make sure that the task is completed by 10/1/2018.	

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K 914	Continued From page 14 This deficient condition was verified by the Enviironmental Services Supervisor.	K 914		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure a multiple outlet connection was in accordance with the 2012 edition of NFPA 99 section 10.2.3.6 item 2 for total ampacity. This deficient practice could cause an overload of a circuit which could cause a power outage to necessary equipment or cause a	K 920	In our maintenance room, we have an extension cord coming out of the ceiling tile. Our facility manager will make sure that this is removed by 9/1/2018. The CFO and CNO will monitor this progress and ensure completion by 9/1/2018.	8/23/18

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K 920	Continued From page 15 fire. This could affect 5 of the 50 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 1:00 pm to 4:00 pm on 07/23/2018 observations and staff interview revealed an extension cord penetrating through the ceiling tile in the maintenance room. This deficient practice was verified by the Environmental Services Supervisor.	K 920		

Electronically delivered
August 13, 2018

Ms. Lori Andreas, Administrator
Appleton Municipal Hospital
30 South Behl Street
Appleton, MN 56208

Re: State Nursing Home Licensing Orders - Project Number S5231028

Dear Ms. Andreas:

The above facility was surveyed on July 23, 2018 through July 26, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00655	A. BUILDING: _____ B. WING _____	07/26/2018

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER 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. 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. 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. 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/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 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 7/9/18 to 7/12/18, 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. THIS WILL APPEAR ON EACH PAGE.	2 000		

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	00655	A. BUILDING: _____ B. WING _____	07/26/2018

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. 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.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening	2 265		8/22/18

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2 265	Continued From page 3 conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the responsible party and physician were notified timely of a alteration in skin integrity for 1 of 1 resident (R25) reviewed for notification of change. Findings include: R25's admission Minimum Data Set (MDS) dated 8/30/17, identified R25 had severe cognitive impairment, and had diagnoses which included dementia, arthritis, depression, and impaired vision. The MDS further identified R25 was not able to walk, required extensive staff assistance with all areas of daily living with the exception of the ability to eat with staff supervision. R25's Admission Record printed 7/25/18, identified R25's family member (FM)-A as R25's responsible party, care conference person, and primary emergency contact #1. On 7/23/18, at 6:39 p.m. during interview, family member (FM)-A identified a concern of poor communication by facility staff in regards to R25's health care and appointments.	2 265	Corrected	

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2 265	Continued From page 4 On 7/25/18, at 7:20 a.m. during observation of provision of morning cares, R25's sheets were noted to have several areas with yellow and tan colored stains, and several spots of what appeared to be dried blood near R25's left elbow. R25's left elbow was noted to have an oval shaped sore approximately 1.5 centimeter (cm) x 1 cm, with the surrounding skin red in color, and extending out from the open area approximately 1 cm. R25's progress notes were reviewed and identified the following entries: -6/28/18. Skin/Wound note: Skin assessment completed with a.m. bath noted bruising to left posterior above elbow measuring 3 x 3.5 x 0 cm. Noted band-aid covering bruising to left posterior lateral side below elbow measuring 4.5 x 2 x 0 cm with intact scabbed skin tear measuring 0.3 x 0.1 x 0, no warmth or redness noted to scabbed area or bruising. R25's record lacked further documentation regarding the skin tear or bruising of the left elbow. The electronic treatment record lacked documentation of the skin tear and bruising or any needed treatments on the left elbow. On 7/25/18, at 8:52 a.m. registered nurse (RN)-A indicated the usual facility protocol for an identified alteration in skin as follows: A skin form is completed in the computer system which triggers a weekly follow up by nursing. The residents physician and family are notified of the skin condition, and if necessary a wound nurse is notified. RN-A reviewed R25's electronic record,	2 265		

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2 265	Continued From page 5 and verified the progress noted dated 6/28/18, which identified R25's skin tear and bruising on the left elbow. RN-A further reviewed R25's medical record and verified no further documentation was found. On 7/25/18, at 9:06 a.m. R25's elbow was visualized by RN-A. RN-A verified R25 had a wound on the left elbow which measured 1.3 x 0.7 cm. RN-A stated, "Someone dropped the ball here." On 7/25/18, at 2:51 p.m. the director of nursing (DON) indicated the the usual facility protocol with a change in condition or skin alteration as follows: 1st- Complete an incident form and skin form. Clean and dress the area appropriately. 2nd- Notify the family and the physician. The DON clarified with the skin form initiated the computer system then has pop-ups weekly to alert the floor nurses to ensure the area is reviewed weekly by licensed staff. The facility policy titled Skin Tears-Abrasions and Minor Breaks, Care of, revised 7/2017, directed under the subtitle Reporting: Notify the responsible family member. Physician notification may be routine (that is, non-immediate) if the abrasion is uncomplicated or not associated with significant trauma. The facility policy titled Notification of Changes, revised 7/2017, identified directed changes in a resident's condition or treatment are immediately shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate. The resident and/or their representative will be educated about treatment options and supported to make an informed choice about care	2 265		

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2 265	Continued From page 6 preferences when there are multiple care options available. All pertinent information will be made available to the provider by the facility staff. SUGGESTED METHOD OF CORRECTION: The DON or designee could work with the medical director to update policies and procedures for when to notify the physician of changes in the resident, and then could educate staff. The DON or designee could also perform audits of resident records to determine if the physician had been notified as appropriate. TIME PERIOD FOR CORRECTION: Thirty (30) days	2 265		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and	2 302		8/22/18

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2 302	Continued From page 7 (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the required initial training on resident Alzheimer's disease and related training including dementia management for 5 of 5 employees (E2, E3, E4, E5, E6) reviewed for dementia care training. Findings include: The Appleton Area Health Services facility assessment dated 11/24/18, included the following: Services and Care we offer Based on our Residents' needs-Mental Health and behavior-Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD (post traumatic stress disorder), other psychiatric diagnoses, intellectual or developmental disabilities. On 7/25/18, the following employee education records were reviewed:	2 302	Corrected	

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2 302	Continued From page 8 - E2, hired as a dietary aid on 6/27/18. -E3, hired as a nursing assistant on 4/26/18. -E4, hired as a dietary aid on 5/30/18. -E5, hired as nursing assistant on 3/14/18. -E6, hired as a nursing assistant on 3/12/18. All five employee records lacked documentation dementia training had been completed. On 7/25/18, at 10:06 .am. the director of nursing (DON) identified the newly hired facility staff had not received training on care of residents with Alzheimer or dementia care. The DON identified the all staff yearly education was set to be completed next week and the new staff would receive the training at that time. The DON indicated new staff were not typically working without training for this length of time, however; identified the facility practice did not include completing the Alzheimer dementia training before working directly with residents. On 7/25/18, at 3:01 p.m. the administrator indicated being aware of the required training regarding Alzheimer's and dementia prior to working directly with patients. The administrator stated, "going forward we will have the training completed." SUGGESTED METHODS OF CORRECTION: The administrator or designee could develop, review, and /or revise policies and procedures to ensure all direct care staff and their supervisors receive training on Alzheimer's/dementia care. The administrator or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee.	2 302		

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2 302	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide grooming and oral hygiene assistance for 1 of 3 residents (R25) who required assistance from staff to complete activities of daily living. Findings include: R25's annual Minimum Data Set (MDS) dated 8/30/17, identified R25 had diagnoses which included dementia, arthritis, depression, and impaired vision. The MDS further identified R25 had severe cognitive impairment,was not able to walk, and required extensive staff assistance with all areas of daily living. R25's care plan revised 9/13/17, identified R25 had dementia, upper dentures and his own lower teeth, and required extensive staff assistance with personal hygiene and oral cares. The care plan identified R25 required oral inspection QD (every day) with oral cares and PRN (as needed),	2 920	Corrected	8/22/18

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2 920	Continued From page 10 On 7/23/18, at 6:27 p.m. family member (FM)-A stated facility staff did not provide R25 daily assistance to shave his face and brush his lower teeth. FM-A stated R25 had shaved daily at home, and liked to be clean shaven. FM-A further indicated R25's breath had been foul in the past and staff were alerted to brush his teeth, however; oral cares continued to not be completed daily. On 7/25/18, at 7:20 a.m. nursing assistant (NA)-C was present in R25's room providing assistance with morning cares. NA-C obtained R25's upper denture from the bathroom, rinsed them with water and placed them in R25's mouth. NA-C then began to organize the room, gather the linens, and garbage. R25 had facial stubble/hair present on his face. NA-C did not offer to shave R25 nor was oral care offered for R25's lower teeth. On 7/25/18, at 7:46 a.m. NA-C verified R25's morning cares were provided as usual. NA-C indicated shaving for R25 was provided as needed. NA-C stated she had not shaved R25 because she felt he did not have enough stubble on his face to require shaving assistance. NA-C indicated R25's dentures were brushed at night and mouth rinsed with a mouth wash, however; R25's teeth were not brushed. Observation of R25's bathroom and above the sink cabinet was conducted with NA-C, NA-C was able to locate denture products and mouthwash. R25's bathroom supplies did not include a tooth brush or tooth paste. On 7/25/18, at 10:06 a.m. the director of nursing (DON) indicated FM-A was very involved with R25's care and would know his choices. The DON indicated she felt the facility honored	2 920		

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2 920	Continued From page 11 resident and family choice of how often a male resident was shaved. The DON confirmed she expected staff provide assistance to shave and brush residents teeth for those who require assistance. The facility policy titled Teeth Brushing, revised 7/2018, The purposes of the procedure are to clean and freshen the resident's mouth, to prevent infections of the mouth, to maintain the teeth and gums in a healthy condition, to stimulate the gums, and to remove food particles from between the teeth. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all employees responsible for providing direct cares for residents the need to follow the residents comprehensive care plan. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document	21385	Corrected	8/22/18

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21385	Continued From page 12	21385		

review, the facility failed to ensure appropriate infection control measures were followed related to the care of catheter drainage bags for 2 of 2 residents (R3, R30) observed with an indwelling catheter.

Findings include:

R3's significant change Minimum Data Set (MDS) dated 4/3/18, indicated R3 was cognitively intact and had diagnoses which included benign prostatic hyperplasia (BPH), obstructive uropathy, and retention of urine. The MDS also indicated R3 required extensive assistance of one staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. R3's MDS further indicated the utilized an indwelling catheter.

R3's care plan, last revised 7/17/18, indicated R3 was at risk for infection related to age, chair fast, community living setting, compromised skin integrity, Diabetes Mellitus, and occasionally incontinent of bladder. R3's care plan further revealed a history of urinary tract infections (UTI), and the use of an indwelling catheter related to BPH, urinary retention, and prostate cancer. The care plan directed staff to complete catheter care twice daily, use catheter secure to decrease risk of trauma, position catheter bag below level of bladder and cover catheter collection bag with catheter cover at all times for dignity.

On 7/25/18, at 7:14 a.m. R3 lay in bed on his back with his eyes closed. His bed was in the lowest position, against a wall, and a maroon fall mat was on the floor next to the bed. A catheter tube was observed between the end of the R3's footboard and the wall. The catheter tubing was followed to the floor where a catheter drainage bag was observed lying flat on the floor with the

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21385	Continued From page 13 side of the bag with the opening spout resting on the floor. No cover was observed on the bag. At 9:36 a.m. nursing assistant (NA)-A entered R3's room to assist him with morning cares. NA-A washed her hands and donned gloves, raised R3's bed and began washing R3's perineal area and catheter tubing. R3's catheter drainage bag remained lying flat on the floor with the side with the opening spout resting directly on the floor. At 9:49 a.m. NA-A stated R3 had a problem emptying his bladder and used a catheter. She went into R3's bathroom, obtained a plastic graduated cylinder, a paper towel, and an alcohol wipe and returned to R3's bed. NA-A placed the paper towel directly on the floor near R3's footboard and placed the plastic cylinder onto the paper towel. NA-A then reached over R3's legs and grabbed the catheter tubing near the footboard and pulled the catheter drainage bag off of the floor. As NA-A pulled up on the tubing, the light yellow urine with white fibrous sediment flowed back up the catheter tubing towards R3's body. NA-A confirmed the catheter drainage bag had laid directly on the floor on it's face and stated the catheter drainage bag was usually stored in a plastic basin on the floor. No plastic basin was noted in R3's room. NA-A then bent down next to the cylinder on the paper towel and opened the drainage bag spout and emptied the bag of it's urine, spilling two small areas approximately three inches in diameter of urine onto the floor. NA-A wiped the drainage bag spout with an alcohol wipe, closed the spout and hung the catheter drainage bag on to the footboard using the attached plastic hook. NA-A then emptied the urine into the toilet, rinsed the cylinder and grabbed a cloth hand towel, soaked it in water and returned to the end of R3's bed. NA-A bent near the spilled areas of urine and	21385		

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21385	Continued From page 14	21385		

wiped them up using the towel with water. NA-A placed the towel in a plastic garbage bag with other dirty linen, removed her gloves and washed her hands.

At 10:08 a.m. NA-A left R3's room and returned with NA-B to assist her with transferring R3 to his power wheelchair. NA-B grabbed R3's catheter drainage bag off of the footboard and attached it to the mechanical stand for the transfer. While transferring the drainage bag multiple drops of urine fell from the drainage spout directly onto the floor. NA-A and NA-B then transferred R3 to his power wheelchair. NA-A took R3's drainage bag off of the mechanical lift and placed it directly onto R3's power wheelchair footrest. NA-B asked NA-A if R3 had a dignity bag (a bag used to conceal a urine drainage bag used for resident dignity purposes and also acts as a barrier for infection control purposes). NA-A stated R3 had one a long time ago and has not seen it in a while. NA-A and NA-B looked in R3's room for a dignity bag, but one was not found. NA-B left R3's room pushing out the mechanical stand. NA-A left R3's room leaving the catheter drainage bag lying directly on R3's power wheelchair footrest between his shoes. Neither NA-A or NA-B were observed to clean the multiple drops of urine on R3's floor. At 10:22 a.m. NA-A returned to R3's room with a black colored dignity bag and attached it to the base of R3's power wheelchair. She then placed the drainage bag inside of the dignity bag.

On 7/26/18, at 8:36 a.m. NA-A was in R3's room assisting him with morning cares. R3's catheter drainage bag laid directly on the floor near the foot end of the bed. NA-A looked at the drainage bag on the floor, picked it up, and placed it on the footboard using the attached plastic hook. NA-A

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21385	Continued From page 15	21385		

stated the drainage bag was on the footboard prior and was moved due to R3 moving around in bed. A plastic basin for holding the drainage bag was not observed on the floor or in R3's room.

On 7/26/18, at 9:35 a.m. trained medication aid (TMA)-A stated catheter drainage bags should never be directly on the floor due to infection control concerns. TMA-A indicated drainage bags should be hooked to the bed frame to keep them in place, but R3's bed was kept in the low position when occupied, so staff would use a plastic basin to place the drainage bag in to keep it off of the floor.

On 7/26/18, at 10:31 a.m. registered nurse (RN)-A stated catheter drainage bags should never touch the floor due to infection control concerns. RN-A indicated R3's catheter drainage bag should be hung by the bed frame, but when his bed was lowered the drainage bag would touch the floor. RN-A stated that staff's normal practice was to use pillow cases to create a barrier between the catheter drainage bag and the floor.

On 7/26/18, at 3:07 p.m. director of nursing (DON) stated R3 had a history of UTIs and was at risk for infection, and developing another UTI. DON stated catheter drainage bags should not be directly on the floor due to infection control issues and contamination of the catheter drainage bag.

R30
R30's quarterly MDS dated 6/12/18, indicated R30 was cognitively intact and had diagnoses which included
neurogenic bladder, bladder disorder and diabetes. The MDS also indicated R30 required extensive assistance of one staff for dressing,

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21385	Continued From page 16 toilet use, personal hygiene and limited assistance of one for bed mobility and transfers. MDS also indicated R30 required the use of an indwelling catheter. R30's care plan revised on 6/27/18, indicated R30 was at risk for infection related to age, chronic disease (renal diseases, congestive heart failure), community living setting, diabetes mellitus, indwelling/intermittent catheterization. R30's care plan indicated R30 had an indwelling catheter related to flaccid bladder. The care plan directed staff to provide catheter care twice daily, position catheter bag and tubing below the level of the bladder, away from entrance of door and when up likes catheter tubing going down left leg. During observations on 7/23/18 at 2:13 p.m. R30 was in her room seated in a brown recliner, R30's catheter tubing ran directly down her left leg all the way to the floor where the catheter drainage bag was observed lying directly on the tile flooring with the opening spout resting directly on the floor and was not covered. R30's catheter tubing and drainage bag had bright yellow urine noted. R30 indicated she did not like her catheter bag not covered and lying on the floor when she had company in her room and stated "I wish they could cover it with something." During observation on 7/24/18 at 10:40 a.m. R30's was seating in her recliner in her room. R30's catheter tubing ran directly down her left leg all the way to the floor where the catheter drainage bag was observed lying directly on the tile flooring with the opening spout resting directly on the floor and was not covered. R30's catheter tubing and drainage bag had bright yellow urine in it.	21385		

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21385	Continued From page 17 During observations on 7/26/18 at 1:50 p.m. R30 was seated in her recliner in her room sleeping. R30's catheter tubing ran directly down her left leg all the way to the floor where the catheter drainage bag was observed lying directly on the tile flooring, spout down and was not covered. R30's catheter tubing and drainage bag had bright yellow urine in it. -at 1:52 RN-A entered R30's room and observed R30's catheter drainage bag lying directly on the tile flooring face down and was not covered. R30's catheter tubing and drainage bag had bright yellow urine in it. RN-A reached for R30's catheter bag lying on the floor, picked it up and hung it on the side of R30's recliner. RN-A confirmed the above finding and verified R30 needed assistance from staff with all catheter cares and activities of daily living (ADL's). RN-A indicated R30's catheter drainage bag should not be lying directly on the floor and should have something around it to protect it like a barrier. RN-A stated this was an infection control issue and dignity. RN-A indicated that normally when residents are in their rooms, staff will use a pillow case to cover the catheter drainage bags. On 7/25/18 at 9:38 a.m. R30 verified when she's in her room, staff will just let her catheter drainage bag rest on the floor full sometimes and not cover it. R30 indicated it was embarrassing when she has had company in her room and its just laying on the floor or hang her catheter bag on the garbage can. On 7/26/18 at 4:23 p.m. DON confirmed R30 needed staff assistance with ADL's, utilized the use of indwelling catheter and needed assistance with catheter cares. DON verified catheter drainage bags need to be covered if	21385		

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21385	Continued From page 18 going on a surface due to infection control issues. The DON also confirmed staff should be covering the catheter bags for dignity issues as well in case she has visitors. The DON indicated his expectations of staff would be to have them cover the catheter drainage bags and indicated staff need to do a better job with this on skills day. Review of facility policy titled, Catheter Care Urinary revised on 7/2018, indicated the purpose of this procedure is to prevent catheter associated urinary tract infections. under infection control: use standard precautions when handling or manipulating the drainage system, maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag and be sure the catheter tubing and drainage bag are kept off the floor. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee(s) may review or revise policies and procedures requiring proper infection control methods , provide an in-service in regard to these policies and procedures, and conduct audits to ensure the policies and procedures are being implemented. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21385		
21710	MN Rule 4658.1415 Subp. 7 Plant Housekeeping, Operation, & Maintenance Subp. 7. Hot water temperature. Hot water supplied to sinks and bathing fixtures must be maintained within a temperature range of 105 degrees Fahrenheit to115 degrees Fahrenheit at the fixtures.	21710		8/22/18

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21710	Continued From page 19 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an environment that was free of accident hazards, related to resident bathroom hot water temperatures in 2 of 3 resident halls. This had the potential to effect all 32 residents who currently resided in those halls. Finding include: On 7/23/18, at 4:34 p.m. room water temperatures were reviewed with the director of maintenance (DM)-A in all three resident hallways of the building. Water temperatures in resident room sinks and bathroom sinks in the North and South hallway were found to be hot to touch in room 203, 206, 209, 214, 217, 247, 240, 250. On 7/23/18, at 5:00 p.m. DM-A verified the water felt too warm, indicated the temperatures were to be between 114 and 117 degrees Fahrenheit (F), however; temperatures did very slightly through out the day. The DM-A indicated the North and South hallways received water from the basement which had a mixing valve where the water that is 140 degrees F is mixed with cool water to reach the 114 to 117 degree F range. The DM-A identified the west wing is regulated by the hospital. The DM-A indicated resident room water temperatures were to be checked daily by a designated maintenance staff person. DM-A identified the water system for the North and South halls, located in the basement had a reading of 118 degree F, however, true water temperatures could not be measured due to the thermometer being misplaced. The DM-A indicated he had now turned down the water	21710	Corrected	

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21710	Continued From page 20 temperature for the North and South halls approximately two degrees F. On 7/24/18, at 1:58 p.m. random room water temperatures at each end and side of the North and South halls were measured with the facility thermometer by the DM-A with the facility thermometer. The following water temperatures were measured in the resident room and bathroom sinks: South hall room 203 through room 225 -room 204 was 119 degrees F -room 213 was 119 degrees F -room 214 was 120 degrees F -room 218 was 119 degrees F -room 222 was 120 degrees F North wing room 230 through room 251 -room 230 /231 shared bathroom was 119 degrees F -room 236 was 118 degrees F -room 240 was 118 degrees F -room 245 was 118 degrees F -room 249 was 119 degrees F -room 251 was 119 degrees F At this time the DM-A indicated the water circulation made a loop, therefore; all other rooms on the South hall would have water temperatures of 119 or 120 degrees F and the room on the North hall would be between 118 and 119 degrees F. The DM-A verified although the water temperature was turned down last evening, the water continued to be too high and would again turn the water temperature down. The facility lacked documentation of the daily water temperature checks. Review of facility policy titled, Safe Water	21710		

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21710	Continued From page 21 Temperature Verification, reviewed 1/1/18, directed: Hot water will be monitored by a competent maintenance technician on a daily basis to insure that our hot water temperature is between the temperatures of 113 degrees Fahrenheit and 117 degrees Fahrenheit. Anything outside of this range is unacceptable and must be managed as efficiently as possible to correct the issue. SUGGESTED METHOD FOR CORRECTION: The Environmental Director, Director of Nursing and/or designee could monitor and develop a system to log the daily temperature checks, educate staff on the policies and audit on a weekly basis to ensure water temperatures are between 105 and 115 degrees Fahrenheit. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21710		
21840	MN St. Statute 144.651 Subd. 12 Patients & Residents of HC Fac.Bill of Rights Subd. 12. Right to refuse care. Competent residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the resident's medical record.	21840		8/22/18

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21840	Continued From page 22 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident current wishes for resuscitation status were accurately documented in the clinical record for 1 of 2 residents (R35) reviewed for advanced directives. Findings include: R35's admission Minimum Data Set (MDS) dated 12/27/17, indicated R35 had intact cognition, and diagnoses which included dementia, atrial fibrillation, chronic obstructive pulmonary disease, and history of pulmonary embolism. Review of R35's Health Care Directive (HCD) dated 12/5/06, indicated no certain code status for R35. However, R35's HCD had Terminal Condition Instructions, that were to be used only if R35 had a terminal condition and was unable to express her wishes. In the event of a terminal condition, R35 wished to be allowed to die naturally and not be kept alive by artificial means or heroic measures. Review of R35's physician signed Care Center Transfer Form dated 12/21/17, indicated R35 wished to have a Do Not Resuscitate (DNR) order. Review of R35's Order Summary Report signed 7/2/18, lacked an order for R35's code status. Review of R35's care plan revised on 7/17/18, indicated on page one, under the header Special Instructions, "Full Code [to resuscitate] 12/21/17".	21840	Corrected	

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21840	Continued From page 23 R35's clinical record did not accurately reflect R35's current wishes for advance directives. On 7/26/18, at 9:29 a.m. trained medication aid (TMA)-A stated to determine a resident's code status, staff would look on the spine of that resident's hard chart for a sticker of a heart. If the resident's chart spine lacked a sticker, they would be considered a DNR. On 7/26/18, at 9:40 a.m. registered nurse (RN)-A stated a resident's code status would be determined by checking the spine of the hard chart for a red heart sticker. If the chart lacked the heart sticker, then there would be a sticker on the inside cover of the chart indicating DNR. RN-A reviewed the spine of R35's hard chart and confirmed R35's chart lacked the sticker. She then opened R35's chart and the sticker on the inside cover indicated "Advanced Directive." RN-A reviewed R35's HCD and indicated it was vague and only stated R35's wishes if she was terminal. RN-A confirmed R35 was not terminal and confirmed the above findings. On 7/26/18, at 9:55 a.m. director of nursing (DON) stated any resident admitted to the facility with a HCD, would meet with the social services designee (SSD) and review their wishes for code status. DON reviewed R35's electronic health record and clinical chart and confirmed the above findings. At 12:00 p.m. during a follow up interview with the DON, he stated the SSD, or her replacement, would be the person to place the red, heart sticker on the spine of the chart, if the resident had wished to have cardiopulmonary resuscitation (CPR). The DON indicated that	21840		

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21840	Continued From page 24 there was no form filled out by residents that choose CPR, and the heart sticker was the indicator that staff would look for to represent the resident's wishes. The DON stated, "This one was missed." At 7/26/18, at 3:48 p.m. during a phone interview with the SSD, she stated upon admission she reviewed R35's HCD with her and at that time she wished to have CPR. SSD stated when a resident wishes to have CPR a red, heart sticker would be placed on the spine of the hard chart by the charge nurse on admission which indicated the residents' wishes. Review of the facility policy titled Advanced Directives approved 7/18, indicated "D. All advance directive document copies will be obtained and located (identify the same section of the resident's medical record that would be readily retrievable by any facility staff)." "E. Resident wishes will be communicated to the staff via the care plan and (identify facility protocol for communication of advance directives either in written or oral format) and to the resident physician." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review the facility policy related to advanced directives and provide education to all staff. The quality assurance designee could monitor records for ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) day	21840		

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21880	Continued From page 25	21880		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section	21880		8/22/18

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21880	Continued From page 26 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide services in a dignified manner for 1 of 2 residents (R30) who utilized a Foley catheter. Finding include: R30's quarterly Minimum Data Set (MDS) dated 6/12/18, indicated R30 was cognitively intact, and had diagnoses which included neurogenic bladder, bladder disorder, and diabetes. The MDS also indicated R30 required extensive assistance of one staff for dressing, toilet use, personal hygiene, and limited assistance of one for bed mobility and transfers. MDS also indicated R30 required the use of an indwelling catheter. R30's care plan revised on 6/27/18, indicated R30 was at risk for infection related to age, chronic disease (renal diseases, congestive heart failure), community living setting, diabetes mellitus, and indwelling/intermittent catheterization. Further review of R30's care plan indicated R30 had an indwelling catheter related to flaccid bladder. The care plan directed staff to provide catheter care twice daily, position catheter bag and tubing below the level of the bladder, away from the entrance of the door, and when up, R30 likes the catheter tubing going down left leg.	21880	Corrected	

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21880	Continued From page 27 During observations on 7/23/18, at 2:13 p.m. R30 was in her room seated in a brown recliner. R30's catheter tubing ran directly down her left leg all the way to the floor, where the catheter drainage bag was observed lying directly on the tile flooring face down and was uncovered. R30's catheter tubing and drainage bag had bright yellow urine noted. R30 indicated she did not like her catheter bag uncovered and lying on the floor when she had company in her room and stated, "I wish they could cover it with something." During observation on 7/24/18, at 10:40 a.m. R30 was seated in her recliner in her room. R30's catheter tubing ran directly down her left leg all the way to the floor, where the catheter drainage bag was observed lying directly on the tile flooring face down and was uncovered. R30's catheter tubing and drainage bag had bright yellow urine in it. -at 2:10 p.m. R30 was seated in her recliner in her room with her feet up on the foot rest of her recliner sleeping. R30's catheter tubing ran directly down her left leg all the way down to the catheter drainage bag which was observed lying directly in a gray basin, which was setting on the floor directly out in front of R30's recliner, and was uncovered. R30's catheter tubing and drainage bag had bright yellow urine in it. During observations on 7/25/18, at 7:29 a.m. R30 was lying in bed with head of bed elevated slightly, and was working on her computer. R30's catheter tubing ran directly down the right side of her bed all the way down to the catheter drainage bag which was observed lying directly in a gray basin, which was setting on the floor directly out on the side of R30's bed and was uncovered. R30's catheter tubing and drainage bag had bright yellow urine in it.	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00655	A. BUILDING: _____ B. WING _____	07/26/2018

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

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21880	Continued From page 28 During observations on 7/26/18, at 1:50 p.m. R30 was seated in her recliner in her room sleeping. R30's catheter tubing ran directly down her left leg all the way to the floor, where the catheter drainage bag was observed lying directly on the tile flooring face down, and was uncovered. R30's catheter tubing and drainage bag had bright yellow urine in it. -at 1:52 registered nurse (RN)-A entered R30's room and observed R30's catheter drainage bag lying directly on the tile flooring face down and uncovered. R30's catheter tubing and drainage bag had bright yellow urine in it. RN-A reached for R30's catheter bag, picked it up, and hung it on the side of R30's recliner. RN-A confirmed finding and verified R30 needed assistance from staff with all catheter cares and activities of daily living (ADLs). RN-A indicated R30's catheter drainage bag should not be lying directly on the floor, and should have something around it to protect it like a barrier. RN-A stated this was an infection control issue and dignity issue. RN-A indicated normally when residents are in their rooms, staff will use a pillow case to cover the catheter drainage bags. On 7/25/18, at 9:38 a.m. R30 verified when she's in her room, staff will just let her catheter drainage bag lay on the floor full sometimes, and not cover it. R30 indicated it was embarrassing when she has had company in her room, when the bag is just laying on the floor or hung on the garbage can. On 7/26/18, at 9:35 a.m. trained medication aid (TMA)-A confirmed catheter drainage bags should not be directly on the floor, but should be covered for dignity.	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00655	A. BUILDING: _____ B. WING _____	07/26/2018

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21880	Continued From page 29 On 7/26/18, at 4:23 p.m. the director of nursing (DON) confirmed R30 needed staff assistance with ADLs, utilized the use of an indwelling catheter, and needed assistance with catheter cares. DON verified catheter drainage bags need to be covered if going on a surface (such as the floor) due to infection control issues. The DON also confirmed staff should be covering the catheter bags for dignity issues in case she has visitors. The DON indicated his expectations of staff would be to have them cover the catheter drainage bags. Review of facility policy titled Quality of Life Dignity revised on 7/2018, indicated each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and/or designee could review and revise policies pertaining to resident rights, educate staff on these policies and perform audits to ensure each resident's rights have been honored. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21880		