#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDIC	ARE/MEDICAID	CERTIFICATION	AND TRANSMITTA
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					AND TRANSMITTAL TE SURVEY AGENCY	ID: HB61 Facility ID: 00655		
1. MEDICARE/MEDICAID PROVIDER NO.       3. NAME AND ADDRESS OF FACILITY         (L1)       245231         2.STATE VENDOR OR MEDICAID NO.       (L4) 30 SOUTH BEHL STREET         (L2)       705040200			LITY H <b>OSPITAI</b>		4. TYPE OF ACTION:       7 (L8)         1. Initial       2. Recertification         3. Termination       4. CHOW         5. Validation       6. Complaint			
5. EFFECTIVE DATE CHANGE OF OWNERSH (L9)	IIP	7. PROVIDER/SU	PPLIER CATEGO	RY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit     9. Other       8. Full Survey After Complaint		
6. DATE OF SURVEY 09/12/2018 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30		
11LTC PERIOD OF CERTIFICATION From (a): To (b):				3:	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN	Following Requirements: 6. Scope of Services Limit 7. Medical Director		
12.Total Facility Beds5013.Total Certified Beds50	(L18) (L17)	B. Not in Co	Acceptable POC mpliance with Prog and/or Applied Wa		4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A	8. Patient Room Size 9. Beds/Room (L12)		
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 50 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (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 :				18. STATE SURVEY AGENCY A	PPROVAL Date:			
Gail Anderson, Unit Superv	risor	(	09/12/2018	(L19)	Joanne Simon, Enforcement Specialist 09/12/2018 (L20)			
PART I	I - TO BI	E COMPLETED	BY HCFA RI	EGIONAI	OFFICE OR SINGLE STA	ATE AGENCY		
<ol> <li>DETERMINATION OF ELIGIBILITY</li> <li>_X1. Facility is Eligible to Participate</li> <li>2. Facility is not Eligible</li> </ol>	(L21)		IPLIANCE WITH GHTS ACT:	CIVIL	<ol> <li>Statement of Financial Solvency (HCFA-2572)</li> <li>Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>Both of the Above :</li> </ol>			
	(E21)							
	IC AGREEM BEGINNING		4. LTC AGREEM ENDING DAT		26. TERMINATION ACTION:       VOLUNTARY       01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24) (l	L41)		(L25)		02-Dissatisfaction W/ Reimbursemen 03-Risk of Involuntary Termination	nt 06-Fail to Meet Agreement		
A		VE SANCTIONS	(L44)		04-Other Reason for Withdrawal	<u>OTHER</u> 07-Provider Status Change 00-Active		
(L27) B	. Rescind Sus	spension Date:						
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
(L2:	8)	03001		(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION ( 09/10/2018	OF APPROVAL D	ATE				
				DETERMINATION APPRO	OVAL			



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



Protecting, Maintaining and Improvingthe 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 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

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDIC	ARE/MEDICAID	CERTIFICATION	AND TRANSMITTA
DADTI	TO DE COMDU	TTED DX THE STA	TE SUDVEN ACEN

					AND TRANSMITTAL TE SURVEY AGENCY	ID: HB61 Facility ID: 00655		
1. MEDICARE/MEDICAID PROVIDER NO.       3. NAME AND ADDRESS OF FACILITY         (L1)       245231         2.STATE VENDOR OR MEDICAID NO.       (L4) 30 SOUTH BEHL STREET         (L2)       705040200			LITY H <b>OSPITAI</b>		4. TYPE OF ACTION:       7 (L8)         1. Initial       2. Recertification         3. Termination       4. CHOW         5. Validation       6. Complaint			
5. EFFECTIVE DATE CHANGE OF OWNERSH (L9)	IIP	7. PROVIDER/SU	PPLIER CATEGO	RY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit     9. Other       8. Full Survey After Complaint		
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11LTC PERIOD OF CERTIFICATION From (a): To (b):				3:	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN	Following Requirements: 6. Scope of Services Limit 7. Medical Director		
12.Total Facility Beds5013.Total Certified Beds50	(L18) (L17)	B. Not in Co	Acceptable POC mpliance with Prog and/or Applied Wa		4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A	8. Patient Room Size 9. Beds/Room (L12)		
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	16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):							
17. SURVEYOR SIGNATURE Date :				18. STATE SURVEY AGENCY A	PPROVAL Date:			
Gail Anderson, Unit Superv	risor	(	09/12/2018	(L19)	Joanne Simon, Enforcement Specialist 09/12/2018 (L20)			
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	(E21)							
	IC AGREEM BEGINNING		4. LTC AGREEM ENDING DAT		26. TERMINATION ACTION:       VOLUNTARY       01-Merger, Closure	05-Fail to Meet Health/Safety		
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A		VE SANCTIONS	(L44)		04-Other Reason for Withdrawal	<u>OTHER</u> 07-Provider Status Change 00-Active		
(L27) B	. Rescind Sus	spension Date:						
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
(L2:	8)	03001		(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION ( 09/10/2018	OF APPROVAL D	ATE				
				DETERMINATION APPRO	OVAL			



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



Protecting, Maintaining and Improvingthe 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 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 ANI	D HUMAN	SERVICES
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### CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDIC	ARE/MED	ICAID C	ERTIFIC	CATION A	AND TRAP	ISMITTA

	CARE/MEDICAID CERTIFICATION		ID: HB61		
PART 1. MEDICARE/MEDICAID PROVIDER NO.	I - TO BE COMPLETED BY THE STA 3. NAME AND ADDRESS OF FACILITY	TE SURVEY AGENCY	Facility ID: 00655           4. TYPE OF ACTION:         2 (L8)		
<ul> <li>(L1) 245231</li> <li>2.STATE VENDOR OR MEDICAID NO.</li> <li>(L2) 705040200</li> </ul>	<ul> <li>(L3) APPLETON MUNICIPAL HOSPITA</li> <li>(L4) 30 SOUTH BEHL STREET</li> <li>(L5) APPLETON, MN</li> </ul>	L (L6) 56208	1. Initial     2. Recertification       3. Termination     4. CHOW       5. Validation     6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGORY           01 Hospital         05 HHA         09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6.     DATE OF SURVEY     07/26/2018     (L34)       8.     ACCREDITATION STATUS:	02 SNF/NF/Dual         06 PRTF         10 NF           03 SNF/NF/Distinct         07 X-Ray         11 ICF/III           04 SNF         08 OPT/SP         12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) <b>09/30</b>		
11LTC PERIOD OF CERTIFICATION From (a): To (b):	10.THE FACILITY IS CERTIFIED AS: A. In Compliance With Program Requirements Compliance Based On:	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN	e Following Requirements: 6. Scope of Services Limit 7. Medical Director		
12.Total Facility Beds     50 (L18)       13.Total Certified Beds     50 (L17)	1. Acceptable POC X B. Not in Compliance with Program Requirements and/or Applied Waivers:	4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: <b>B</b> *	) 8. Patient Room Size 9. Beds/Room (L12)		
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 50	ICF IID	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38) (L39) 16. STATE SURVEY AGENCY REMARKS (IF APPLICAE 17. SURVEYOR SIGNATURE	(L42) (L43) ELE SHOW LTC CANCELLATION DATE):	18. STATE SURVEY AGENCY A	APPROVAL Date:		
Jonathan Anderson, HFE - NE II	08/31/2018 (L19)	Joanne Simon, Enforcement Specialist 09/07/2018 (L20)			
PART II - TO B	E COMPLETED BY HCFA REGIONA	L OFFICE OR SINGLE STA			
<ul> <li>19. DETERMINATION OF ELIGIBILITY</li> <li>X 1. Facility is Eligible to Participate</li> <li>2. Facility is not Eligible</li> <li>(L21)</li> </ul>	20. COMPLIANCE WITH CIVIL RIGHTS ACT:	<ol> <li>Statement of Finan</li> <li>Ownership/Control</li> <li>Both of the Above</li> </ol>	Interest Disclosure Stmt (HCFA-1513)		
22. ORIGINAL DATE 23. LTC AGREE	MENT 24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION BEGINNING 08/01/1982	G DATE ENDING DATE	VOLUNTARY <u>00</u> 01-Merger, Closure			
	(L25) TVE SANCTIONS on of Admissions:	02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	nt 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change 00-Active		
(L27) B. Rescind S	(L44) uspension Date: (L45)		00-Active		
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. REMARKS			
(L28)	<b>03001</b> (L31)				
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF APPROVAL DATE	1			
(L32)	(L33)	DETERMINATION APPR	OVAL		



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:

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

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

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

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

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

Appleton Municipal Hospital August 13, 2018 Page 2 Please note, it is your response

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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,

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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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			· ·		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	•		0	MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245231	B. WING			07/	26/2018
NAME OF F	PROVIDER OR SUPPLIER		· [	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
APPLET	ON MUNICIPAL HOSF	PITAL			) SOUTH BEHL STREET PPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00			
F 000	Emergency Prepare conducted on July 2 during a recertificat		F0	00			
	survey was comple Minnesota Departm your facility was in o of 42 CFR Part 483	h July 26, 2018, a standard ted at your facility by the nent of Health to determine if compliance with requirements 8, Subpart B, and ong Term Care Facilities.					
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 550 SS=D	on-site revisit of you validate that substa regulations has bee your verification.		F 5	50			9/4/18
	self-determination, access to persons a outside the facility, this section.	right to a dignified existence, and communication with and and services inside and including those specified in					
		DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically 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.

PRINTED: 08/31/2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES							APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COM	PLETED
		245231	B. WING			07/2	26/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSP	PITAL			) SOUTH BEHL STREET PPLETON, MN 56208		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION DATE
F 550	Continued From pa	ge 1	F 5	50			
	8483 10(a)(1) A fac	ility must treat each resident					
	with respect and dig	gnity and care for each					
		er and in an environment that					
		nce or enhancement of his or ecognizing each resident's					
	individuality. The fac	cility must protect and					
	promote the rights of	of the resident.					
		facility must provide equal					
	access to quality ca	are regardless of diagnosis,					
		n, or payment source. A facility maintain identical policies and					
	practices regarding	transfer, discharge, and the					
		s under the State plan for all					
	residents regardies	s of payment source.					
	§483.10(b) Exercise						
		e right to exercise his or her of the facility and as a citizen					
	or resident of the U	2					
	8483.10(b)(1) The f	facility must ensure that the					
	resident can exercis	se his or her rights without					
	interference, coercient from the facility.	on, discrimination, or reprisal					
	from the facility.						
		resident has the right to be					
		, coercion, discrimination, and cility in exercising his or her					
		oported by the facility in the					
		er rights as required under this					
	subpart. This REQUIREMEN by:	NT is not met as evidenced					
	Based on observat	tion, interview, and document			1) Resident R30 now has a dignity	bag in	
		ailed to provide services in a			place and is noted in the care plan.		
	utilized a Foley cath	r 1 of 2 residents (R30) who neter.			Resident R30's catheter bag will be monitored for proper catheter care/		

Facility ID: 00655

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		AND HUMAN SERVICES & MEDICAID SERVICES			F	FORM /	08/31/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		X3) DATE	SURVEY PLETED
		245231	B. WING _			07/2	26/2018
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
APPLETON MUNICIPAL HOSPITAL					SOUTH BEHL STREET PPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	Continued From pa	ge 2	F 55	50	handling.		
	6/12/18, indicated F had diagnoses whic bladder, bladder dis MDS also indicated assistance of one s personal hygiene, a for bed mobility and R30 required the us R30's care plan rev R30 was at risk for chronic disease (ref	imum Data Set (MDS) dated 30 was cognitively intact, and sh included neurogenic sorder, and diabetes. The R30 required extensive taff for dressing, toilet use, and limited assistance of one transfers. MDS also indicated se of an indwelling catheter. ised on 6/27/18, indicated infection related to age, nal diseases, congestive heart			<ul> <li>2) All residents with catheters were identified and also were verified to ha dignity bags covering their drainage be All residents with catheter bags will be monitored during cares for proper catheter care/bag handling.</li> <li>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, star received education regarding all of the areas of concern listed by state surver</li> </ul>	bags. be th aff ne eyors	
	mellitus, and indwe catheterization. Fur indicated R30 had a to flaccid bladder. T provide catheter ca catheter bag and tu bladder, away from when up, R30 likes down left leg. During observations was in her room se catheter tubing ran the way to the floor, bag was observed I face down and was tubing and drainage noted. R30 indicate bag uncovered and	ther review of R30's care plan an indwelling catheter related the care plan directed staff to re twice daily, position bing below the level of the the entrance of the door, and the catheter tubing going s on 7/23/18, at 2:13 p.m. R30 ated in a brown recliner. R30's directly down her left leg all where the catheter drainage ying directly on the tile flooring uncovered. R30's catheter bag had bright yellow urine d she did not like her catheter lying on the floor when she room and stated, "I wish they			at an educational session on August 2018. 4)Audits on R30's dignity bag placem will be completed by DON 3 times we for 4 weeks. Results will then be repo to QA to determine how frequently following that 4 week period. Audits we also be completed by DON 3 times we on random residents with indwelling catheters to check for dignity bag placement for 4 weeks. Those result also be reported to QA to determine r appropriate steps. R30's catheter cares/bag handling will be audited 3x weekly for 4 weeks and the results wi brought to QA. Random audits of catheter care/bag handling will be completed 3x weekly for 4 weeks on random residents with indwelling catheters.	nent eekly orted will veekly ts will next ¢	

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		AND HUMAN SERVICES			FORM	08/31/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245231	B. WING		07/:	26/2018
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSF	PITAL		© SOUTH BEHL STREET APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 550	During observation was seated in her re- catheter tubing ran the way to the floor, bag was observed I face down and was tubing and drainage it. -at 2:10 p.m. R30 w her room with her fe recliner sleeping. R directly down her le catheter drainage b directly in a gray ba floor directly out in f was uncovered. R3 drainage bag had b During observations was lying in bed wit slightly, and was wo catheter tubing ran her bed all the way bag which was obse basin, which was se on the side of R30's R30's catheter tubin bright yellow urine i During observations was seated in her re R30's catheter tubin leg all the way to the drainage bag was of tile flooring face dow catheter tubing and yellow urine in it. -at 1:52 registered to	on 7/24/18, at 10:40 a.m. R30 ecliner in her room. R30's directly down her left leg all , where the catheter drainage lying directly on the tile flooring a uncovered. R30's catheter e bag had bright yellow urine in was seated in her recliner in eet up on the foot rest of her 30's catheter tubing ran off leg all the way down to the bag which was observed lying asin, which was setting on the front of R30's recliner, and 60's catheter tubing and bright yellow urine in it. s on 7/25/18, at 7:29 a.m. R30 th head of bed elevated brking on her computer. R30's directly down the right side of down to the catheter drainage erved lying directly in a gray etting on the floor directly out s bed and was uncovered. ng and drainage bag had	F 550			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	08/31/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		245231	B. WING		07/2	26/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSE	PITAL		30 SOUTH BEHL STREET APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 550	lying directly on the uncovered. R30's c bag had bright yello for R30's catheter b on the side of R30's finding and verified staff with all catheter living (ADLs). RN-A drainage bag shoul floor, and should ha protect it like a barr infection control iss indicated normally of rooms, staff will use catheter drainage bag in her room, staff will use catheter drainage bag in her room, staff will use catheter drainage bag in her room, staff will when she has had of the bag is just layin garbage can. On 7/26/18, at 9:35 (TMA)-A confirmed should not be direc covered for dignity. On 7/26/18, at 4:23 (DON) confirmed R with ADLs, utilized to catheter, and need catheter, and need catheter bags for dignity	<ul> <li>tile flooring face down and catheter tubing and drainage ow urine in it. RN-A reached bag, picked it up, and hung it is recliner. RN-A confirmed R30 needed assistance from er cares and activities of daily A indicated R30's catheter</li> <li>Id not be lying directly on the ave something around it to rier. RN-A stated this was an sue and dignity issue. RN-A when residents are in their e a pillow case to cover the bags.</li> <li>B a.m. R30 verified when she's rill just let her catheter in the floor full sometimes, and dicated it was embarrassing company in her room, when region the floor or hung on the floor, but should be it would be floor, but should be</li> </ul>	F 550			

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		AND HUMAN SERVICES			FORM	08/31/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245231	B. WING		07/	26/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSP	יודאL		30 SOUTH BEHL STREET APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 550	staff would be to ha drainage bags. Review of facility po	ave them cover the catheter	F 550	)		
F 578 SS=D	shall be cared for in enhances quality of individuality. Request/Refuse/Ds	7/2018, indicated each resident n a manner that promotes and f life, dignity, respect, and scntnue Trmnt;FormIte Adv Dir 6)(8)(g)(12)(i)-(v)	F 578	3		9/4/18
	discontinue treatme	right to request, refuse, and/or ent, to participate in or refuse perimental research, and to nce directive.				
	construed as the rig the provision of me	ing in this paragraph should be ght of the resident to receive dical treatment or medical nedically unnecessary or				
	requirements specifi subpart I (Advance (i) These requirement inform and provide residents concerning medical or surgical resident's option, fo (ii) This includes a w facility's policies to it and applicable State (iii) Facilities are per entities to furnish the legally responsible for requirements of this	ents include provisions to written information to all adult ng the right to accept or refuse treatment and, at the ormulate an advance directive. written description of the implement advance directives te law. ermitted to contract with other his information but are still for ensuring that the				

Facility ID: 00655

If continuation sheet Page 6 of 28

AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING       COMPLETED         NAME OF PROVIDER OR SUPPLIER       B. WING       STREET ADDRESS, CITY, STREE, ZP CODE       07/26/2018         APPLETON MUNICIPAL HOSPITAL       STREET ADDRESS, CITY, STREE, ZP CODE       30 SOUTH BEHL STREET       APPLETON, NN 56208         (X4) ID PREFIX       SUMMARY STATEMENT OF DEFICIENCIES RECOLLATORY OR LSC IDENTIFYING INFORMATION       PREFIX PREFIX       PROVIDERS OR CORRECTION HOUSE BE PROPORTING PROVIDERS OF CORRECTION HOUSE BE PROPORTING INFORMATION       OWNE         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.       F 578       F 578         ID Resident R35 was met with and determined her wise so for resuscitation status were accurately documented in the clinical record for 1 of 2 residents (R35) reviewed for advanced directives.       1) Resident R35 was met with and determined her wise bas to be full code. A red heart was placed on the grine 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 char's will also be reviewed of their care plan to ensure both DNR and DNI match resident wishes.       2) All resident's char's will also be reviewed to their care plan to ensure both DNR and DNI match resident wishes.         Rolina do 12/27/17, indicated R35 Health Care Directive (HCD) dated 12/27/16, indicated no	CENTER		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			FORM. MB NO.	08/31/2018 APPROVED 0938-0391 SURVEY
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         APPLETON MUNICIPAL HOSPITAL       STREET ADDRESS, CITY, STATE, ZIP CODE         (X4) ID PREEM       SUMMARY STATEMENT OF DEFICIENCIES (EACH OPARETTER FT TAG       PROVIDERS PLAN OF CORRECTION (EACH CORRECTIPA OFTICH SHOULD BE (EACH CORRECTIPA OFTICH MINITURE SHOULD BE (EACH CORRECTIPA OFTICH MINITUR MINITUR SHOULD BE (EACH CORRECTIPA OFTICH MINITUR MI							
APPLETON MUNICIPAL HOSPITAL         30 SOUTH BEHL STREET APPLETON, MM SEQ08           PHIER TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH OPRICIVE ACTION SHOLD BE (EACH OPRICIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         0           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 failed to ensure resident current wishes for resuscitation status were accurately documented in the clinical record for 1 of 2 residents (RS5) reviewed for advanced directives.         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 S5's dad intact cognition, and diagnoses which included dementia, atila fibrillation, chronic obstructive pulmonary disease, and history of pulmonary embolism.         2) All resident's physician orders will be reviewed and compared to ther care plan to ensure bot DNR and DNI match resid			245231	B. WING		07/2	26/2018
APPLETON MUNICIPAL HOSPITAL         APPLETON, MN 56208           [04] ID PREFIX TAG         ISUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDENS FLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDENS FLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDENS FLAN OF CORRECTION (EACH ORRECTION (EACH DEFICIENCY)         COMMENT (EACH DEFICIENCY)           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.         F 578         F 578           (V) The facility is not relieved of its obligation to provide this information. Follow-up procedures must be in place to provide the enformation 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 10 2 resident's (R35) reviewed for advanced directives.         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.           R35's admission Minimum Data Set (MDS) dated 12/27/17, indicated R35 had intact cognition, and diagnoses	NAME OF F	PROVIDER OR SUPPLIER					
PRÉFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PRÉFIX TAG       CEACH CORRECTIVE ACTION SHOULD BE CROSSRECTENC ACTION SHOULD BE CROSSRECTENC ACTION SHOULD BE DEFICIENCY)       COMPLET INFORMATION         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.       F 578         (v) The facility is not relieved of its obligation to provide this 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.       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 for full code has also been received and documented.         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.       2) All resident's charts will also be reviewed to ensure that the orders in the chart match the resident wishes.         8) Policy to be reviewed/revised and gone over with staff at September 4th, 2018 education provided on August 1s, 2018	APPLET	ON MUNICIPAL HOSF	PITAL				
<ul> <li>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.</li> <li>(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:</li> <li>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.</li> <li>Findings include:</li> <li>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.</li> <li>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</li> </ul>	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	) BE	(X5) COMPLETION DATE
condition, R35 wished to be allowed to die naturally and not be kept alive by artificial means or heroic measures.regarding the aleas of concentrals 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 physicianReview of R35's physician signed Care Centerensure resident wishes match physician	F 578	time of admission a information or article has executed an ac may give advance of individual's resident with State Law. (v) The facility is no provide this informat or she is able to reac Follow-up procedur the information to the appropriate time. This REQUIREMEN by: Based on interview facility failed to ensu- resuscitation status in the clinical record reviewed for advant Findings include: R35's admission M 12/27/17, indicated diagnoses which in- fibrillation, chronic of and history of pulme Review of R35's He dated 12/5/06, indic for R35. However, I Condition Instructio R35 had a terminal express her wishes condition, R35 wish naturally and not be or heroic measures	ind is unable to receive ulate whether or not he or she dvance directive, the facility directive information to the trepresentative in accordance t relieved of its obligation to ation to the individual once he seive such information. es must be in place to provide he individual directly at the NT is not met as evidenced v and document review, the ure resident current wishes for were accurately documented d for 1 of 2 residents (R35) ced directives. inimum Data Set (MDS) dated R35 had intact cognition, and cluded dementia, atrial obstructive pulmonary disease, onary embolism. ealth Care Directive (HCD) eated no certain code status R35's HCD had Terminal ns, that were to be used only if condition and was unable to . In the event of a terminal hed to be allowed to die e kept alive by artificial means		<ol> <li>Resident R35 was met with and determined her wish to be full code heart was placed on the spine of h medical record the day that it was to attention. Order from provider for code has also been received and documented.</li> <li>All resident's physician orders w reviewed and compared to their cat to ensure both DNR and DNI matc resident wishes. All resident's chat also be reviewed to ensure that the in the chart match the resident wis</li> <li>Policy to be reviewed/revised ar over with staff at September 4th, 2 educational session in addition to tt education provided on August 1st, regarding the areas of concern as by state surveyors. The updated p will reflect that Social Services will with the new admit on admission a review code status with the resider</li> </ol>	e. A red er brought or full rill be tre plan h rts will e orders hes. 018 he 2018 listed policy meet nd nt and	

Facility ID: 00655

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 245231 07/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **30 SOUTH BEHL STREET** APPLETON MUNICIPAL HOSPITAL APPLETON, MN 56208 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 578 Continued From page 7 F 578 Transfer Form dated 12/21/17, indicated R35 orders. Social Service designee reviews code status with residents every 3 months wished to have a Do Not Resuscitate (DNR) and will ensure that the resident wishes order. continue to match physician orders. If a resident changes their wishes, a new Review of R35's Order Summary Report signed 7/2/18. lacked an order for R35's code status. physicians order will be completed to reflect those wishes. Review of R35's care plan revised on 7/17/18, indicated on page one, under the header Special 4) Assess all new admissions for records Instructions, "Full Code [to resuscitate] 12/21/17". for accuracy and consistency regarding code status for 3 months. Results to be R35's clinical record did not accurately reflect reported to QA to determine further action R35's current wishes for advance directives. needed at that time. Social Services to meet with all resident's to review advanced directives wishes to ensure On 7/26/18, at 9:29 a.m. trained medication aid physician orders match their wishes. (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

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		AND HUMAN SERVICES				FORM	08/31/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245231	B. WING			07/:	26/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSF	PITAL		-	0 SOUTH BEHL STREET APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 578	with a HCD, would designee (SSD) and status. DON review record and clinical of findings. At 12:00 p.m. during DON, he stated the would be the person sticker on the spine had wished to have resuscitation (CPR) there was no form f choose CPR, and the indicator that staff v resident's wishes. T was missed." At 7/26/18, at 3:48 g with the SSD, she sereviewed R35's HC wished to have CPF placed on the spine charge nurse on ad residents' wishes. Review of the facilit Directives approved advance directive d obtained and locate the resident's medic readily retrievable b Resident wishes wi via the care plan an communication of a	meet with the social services d review their wishes for code yed R35's electronic health chart and confirmed the above g a follow up interview with the sSD, or her replacement, n to place the red, heart e of the chart, if the resident		578			

Facility ID: 00655

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO (X3) DAT	E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:			CON	<b>IPLETED</b>
		245231	B. WING		07	/26/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSE	PITAL		80 SOUTH BEHL STREET APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 580	Continued From pa	ige 9	F 580			
F 580 SS=D	Notify of Changes ( CFR(s): 483.10(g)(	Injury/Decline/Room, etc.) 14)(i)-(iv)(15)	F 580			9/4/18
	<ul> <li>(i) A facility must im consult with the resist consistent with the resist consistent with his representative(s) with a construction of the second seco</li></ul>	olving the resident which I has the potential for requiring on; ange in the resident's physical, ocial status (that is, a Ith, mental, or psychosocial threatening conditions or				
	<ul> <li>§483.15(c)(1)(ii).</li> <li>(ii) When making n</li> <li>(14)(i) of this section</li> <li>all pertinent information is available and prophysician.</li> <li>(iii) The facility mustor resident and the resident is specified in §483 (B) A change in resident resident in the resident in the resident in the section as specified in §483 (B) A change in resident in the section is a specified in the section in the section in the section is a specified in the section in the section in the section is a specified in the section in the section in the section is a specified in the section in the section in the section is a specified in the section in the section in the section is a specified in the section in the section is a specified in the section in the section in the section is a specified in the section in the section in the section is a specified in the section in the section is a specified in the section in the section in the section is a specified in the section in the section in the section is a specified in the section in the section in the section is a specified in the section in the section in the section is a specified in the section in the section in the section is a specified in the section in the section in the section is a specified in the section in the section in the section is a specified in the section in the section in the section is a specified in the section in the section in the section is a specified in the section in the section in the section is a specified in the section in the se</li></ul>	otification under paragraph (g) n, the facility must ensure that ation specified in §483.15(c)(2) wided upon request to the at also promptly notify the sident representative, if any, or or roommate assignment 3.10(e)(6); or ident rights under Federal or tions as specified in paragraph on.				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/31/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		245231	B. WING			07/2	26/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSP	PITAL			0 SOUTH BEHL STREET PPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	that is a composite §483.5) must disclo its physical configur locations that comp part, and must spee room changes betw under §483.15(c)(9) This REQUIREMEN by: Based on observat review, the facility fa party and physician alteration in skin int reviewed for notifica Findings include: R25's admission Mi 8/30/17, identified F impairment, and ha dementia, arthritis, vision. The MDS fut able to walk, require with all areas of dai the ability to eat with Admission Record p R25's family member responsible party, c primary emergency On 7/23/18, at 6:39 member (FM)-A ide communication by f	apposite distinct part. A facility distinct part (as defined in use in its admission agreement ration, including the various rise the composite distinct cify the policies that apply to veen its different locations ). NT is not met as evidenced ion, interview, and document ailed to ensure the responsible were notified timely of a egrity for 1 of 1 resident (R25) ation of change.	F 5	80	<ol> <li>Medical director and DON will repolicy and procedure and update accordingly. R25's family was notifie the skin tear on the day of finding th had not been communicated. Resire R25's incident reports will be review from the last quarter and family and will be notified of any incidents that not been documented to have been communicated to them.</li> <li>Review all residents chart from th 30 days to identify all notifiable instances according to policy, that occurred a appropriate parties (MD and family) not notified, staff will notify the appr parties at the time of finding. Will co to monitor future notifiable incidents additional months.</li> <li>Review policy/procedure with state ducate staff on September 4th, 20</li> </ol>	ed of nat it dent ved 1 MD have have n he last ances. , nd the opriate opriate opriate optinue s for 2	
	member (FM)-A ide	ntified a concern of poor acility staff in regards to R25's			3) Review policy/procedure with sta	18 at	

Facility ID: 00655

PRINTED: 08/31/2018

TATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	0938-039 E SURVEY PLETED
		245231	B. WING		07/2	26/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
APPLET	ON MUNICIPAL HOSF	ITAL		30 SOUTH BEHL STREET APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 580	On 7/25/18, at 7:20 provision of morning noted to have sever colored stains, and appeared to be drie R25's left elbow wa shaped sore approx 1 cm, with the surre extending out from cm. R25's progress note identified the follow -6/28/18. Skin/Wou completed with a.m posterior above elb Noted band-aid cov lateral side below e with intact scabbed x 0, no warmth or re or bruising. R25's record lacked regarding the skin t elbow. The electronic treat documentation of th any needed treatment On 7/25/18, at 8:52 indicated the usual identified alteration is completed in the triggers a weekly for	a.m. during observation of g cares, R25's sheets were ral areas with yellow and tan several spots of what d blood near R25's left elbow. s noted to have an oval kimately 1.5 centimeter (cm) x ounding skin red in color, and the open area approximately 1 es were reviewed and ing entries: and note: Skin assessment . bath noted bruising to left ow measuring $3 \times 3.5 \times 0$ cm. ering bruising to left posterior lbow measuring $4.5 \times 2 \times 0$ cm skin tear measuring $0.3 \times 0.1$ edness noted to scabbed area	F 58	<ul> <li>received education regarding notion of changes on August 1st, 2018 a meeting that discussed the areas concern as stated by state survey</li> <li>4) MDS coordinators will audit all changes in condition that require and MD notification from the last for all residents. All changes that MD and family notification will be for 2 months and reported to QA the deficiency does not recur. Fu action will be determined by QA committee following data collection to determine if further monitoring required.</li> </ul>	at nursing of yors. I family 30 days require audited to ensure inther on period	

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245231	B. WING			07/:	26/2018
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSF	PITAL			30 SOUTH BEHL STREET APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	notified. RN-A revie and verified the pro which identified R22 the left elbow. RN-A medical record and documentation was On 7/25/18, at 9:06 visualized by RN-A. wound on the left el 0.7 cm. RN-A stated here." On 7/25/18, at 2:51 DON) indicated the a change in condition 1st- Complete an im Clean and dress the 2nd- Notify the fami The DON clarified w computer system the alert the floor nurse reviewed weekly by The facility policy tit Minor Breaks, Care under the subtitle R responsible family r may be routine (tha abrasion is uncomp significant trauma. The facility policy tit revised 7/2017, idea representative, accor reported to the attent	ewed R25's electronic record, gress noted dated 6/28/18, 5's skin tear and bruising on A further reviewed R25's verified no further found. a.m. R25's elbow was RN-A verified R25 had a bow which measured 1.3 x d, "Someone dropped the ball p.m. the director of nursing ( the usual facility protocol with on or skin alteration as follows: icident form and skin form. e area appropriately. ily and the physician. with the skin form initiated the nen has pop-ups weekly to is to ensure the area is f licensed staff.	F 5	580			

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						<u>. 0938-039</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		245231	B. WING _		07/	26/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSF	PITAL		30 SOUTH BEHL STREET APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIO DATE
F 580	to make an informe preferences when t available. All pertine available to the pro-	atment options and supported d choice about care here are multiple care options ent information will be made vider by the facility staff.	F 58			
F 677 SS=D	CFR(s): 483.24(a)(a) §483.24(a)(2) A res- out activities of daily services to maintain personal and oral h This REQUIREMEN by: Based on observat review, the facility fa- oral hygiene assista who required assista activities of daily live Findings include: R25's annual Minim 8/30/17, identified F included dementia, impaired vision. The had severe cognitiv	ident who is unable to carry y living receives the necessary n good nutrition, grooming, and ygiene; NT is not met as evidenced ion, interview, and document ailed to provide grooming and ance for 1 of 3 residents (R25) ance from staff to complete ing. num Data Set (MDS) dated R25 had diagnoses which arthritis, depression, and e MDS further identified R25 e impairment,was not able to	F 67	<ol> <li>Review oral care and personal as it relates to shaving plan of care family and staff and update care pl accordingly to ensure staff knows f appropriate way to care for R25 as relates to oral cares and personal (shaving).</li> <li>Reviewing/assessing oral cares personal hygiene as it relates to sh for all other residents will be compl (see audits).</li> </ol>	e with an the s it hygiene and naving leted	9/4/18
	all areas of daily livi R25's care plan rev had dementia, uppe teeth, and required with personal hygie plan identified R25 (every day) with ora	extensive staff assistance with ng. vised 9/13/17, identified R25 er dentures and his own lower extensive staff assistance ne and oral cares. The care required oral inspection QD I cares and PRN (as needed), p.m. family member (FM)-A		3) Policy to be reviewed with staff a September 4th, 2018 educational r in addition to the education received August 1st, 2018 related to the are concern as stated by state surveyd exit interview. Education will include appropriate way to complete oral c and personal hygiene cares which shaving all residents with facial had depending on resident preference.	meeting ed on eas of ors upon de the ares include ir,	

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		E & MEDICAID SERVICES	(X2) MILL				0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245231	B. WING _			07/2	26/2018
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON MUNICIPAL HOS	PITAL			0 SOUTH BEHL STREET PPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 677	assistance to shaw teeth. FM-A stated home, and liked to indicated R25's brea and staff were aler however; oral care completed daily. On 7/25/18, at 7:20 was present in R29 with morning cares denture from the b water and placed t then began to orga linens, and garbag present on his face R25 nor was oral of teeth. On 7/25/18, at 7:40 morning cares wer indicated shaving f needed. NA-C stat because she felt h on his face to requi indicated R25's de and mouth rinsed of R25's teeth were in R25's bathroom ar conducted with NA denture products a bathroom supplies or tooth paste. On 7/25/18, at 10:0 (DON) indicated F	age 14 did not provide R25 daily re his face and brush his lower R25 had shaved daily at be clean shaven. FM-A further eath had been foul in the past ted to brush his teeth, is continued to not be 0 a.m. nursing assistant (NA)-C 5's room providing assistance s. NA-C obtained R25's upper eathroom, rinsed them with hem in R25's mouth. NA-C anize the room, gather the le. R25 had facial stubble/hair e. NA-C did not offer to shave care offered for R25's lower 6 a.m. NA-C verified R25's re provided as usual. NA-C for R25 was provided as ted she had not shaved R25 e did not have enough stubble ire shaving assistance. NA-C intures were brushed at night with a mouth wash, however; not brushed. Observation of hd above the sink cabinet was a-C, NA-C was able to locate and mouthwash. R25's did not include a tooth brush 06 a.m. the director of nursing M-A was very involved with ould know his choices. The	F 6	77	4) Audits to be completed for R25's cares to be completed 4 times wee four weeks to be completed by floo nursing licensed staff with assistan from resident's wife who visits daily will have audits completed as they to personal hygiene and shaving 42 weekly for four weeks. Random resident's oral cares will be audited times per week for 4 weeks to ensure are completed according to care pl Random residents personal hygien relates to shaving will also be audit times per week for four weeks to eithe cares are being completed acc to care plan to ensure that the procesustained following the education. It is reported to QA and then dete appropriate action going forward.	kly for r ce relate c l 3 ure they an. e as it ed 3 nsure ording cess is Results	

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		IG		PLETED
		245231	B. WING _		07/	26/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSF	PITAL		30 SOUTH BEHL STREET APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 677	resident was shave expected staff provi brush residents tee assistance. The facility policy tit 7/2018, The purpos clean and freshen t prevent infections o teeth and gums in a	ge 15 choice of how often a male d. The DON confirmed she ide assistance to shave and th for those who require led Teeth Brushing, revised ses of the procedure are to he resident's mouth, to f the mouth, to maintain the a healthy condition, to , and to remove food particles	F 67	77		
F 880 SS=D	from between the te Infection Prevention CFR(s): 483.80(a)( \$483.80 Infection C The facility must es infection prevention designed to provide comfortable enviror	eeth. a & Control 1)(2)(4)(e)(f) control tablish and maintain an and control program a safe, sanitary and ment and to help prevent the ansmission of communicable	F 88	30		9/4/18
	program. The facility must es and control program a minimum, the follo §483.80(a)(1) A sys reporting, investigat and communicable staff, volunteers, vis providing services u arrangement based	tem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual I upon the facility assessment of to §483.70(e) and following				

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		AND HUMAN SERVICES				FORM	APPROVED	
						MB NO. 0938-0391 (X3) DATE SURVEY		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
			A. DUILUI	NG_				
		245231	B. WING _			07/2	26/2018	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1		
APPLET	ON MUNICIPAL HOSP	PITAL			0 SOUTH BEHL STREET			
/			<u> </u>	Α	PPLETON, MN 56208			
(X4) ID PREFIX			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION	
TAG		SC IDENTIFYING INFORMATION)	TAG	Ì	CROSS-REFERENCED TO THE APPROPI		DATE	
	L		<u> </u>		DEFICIENCY)			
				~ ~				
F 880	Continued From pa	.ge 16	F 8	80				
	8483 80(a)(2) Writt	en standards, policies, and						
		program, which must include,						
	but are not limited t	0:						
		eillance designed to identify						
	possible communic	able diseases or ey can spread to other						
	persons in the facili	, ,						
	(ii) When and to wh	nom possible incidents of						
		ease or infections should be						
	reported; (iii) Standard and tr	enemicsion based procestions						
		ansmission-based precautions event spread of infections;						
		isolation should be used for a						
	resident; including t	but not limited to:						
		uration of the isolation,						
	involved, and	e infectious agent or organism						
		hat the isolation should be the						
	least restrictive pos	sible for the resident under the						
	circumstances.							
		ces under which the facility						
		oyees with a communicable skin lesions from direct						
		nts or their food, if direct						
	contact will transmit	t the disease; and						
		ne procedures to be followed						
	by staff involved in o	direct resident contact.						
	\$483.80(a)(4) A svs	stem for recording incidents						
		facility's IPCP and the						
	corrective actions ta	aken by the facility.						
	\$400.00/a) Linana							
	§483.80(e) Linens. Personnel must har	ndle, store, process, and						
		as to prevent the spread of						
	infection.							

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		AND HUMAN SERVICES				FORM	08/31/2018 APPROVED 0938-0391
		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245231			ì		07/26/2018	
NAME OF PROVIDER OR SUPPLIER APPLETON MUNICIPAL HOSPITAL					STREET ADDRESS, CITY, STATE, ZIP CODE 30 SOUTH BEHL STREET APPLETON, MN 56208	<u>.</u>	
(X4) ID PREFIX TAG	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			TIX i	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	<ul> <li>§483.80(f) Annual r The facility will cond IPCP and update th This REQUIREMEN by:</li> <li>Based on observatireview, the facility finfection control meto to the care of cather residents (R3, R30) catheter.</li> <li>Findings include:</li> <li>R3's significant chat dated 4/3/18, indicationand had diagnoses prostatic hyperplasition of urin R3 required extensible bed mobility, transfipersonal hygiene. Futilized an indwellin</li> <li>R3's care plan, last was at risk for infection community living set integrity, Diabetes I incontinent of blador revealed a history of and the use of an in BPH, urinary retent care plan directed st twice daily, use cation bladder and cover of catheter cover at all</li> </ul>	eview. duct an annual review of its heir program, as necessary. NT is not met as evidenced tion, interview, and document ailed to ensure appropriate easures were followed related ter drainage bags for 2 of 2 ) observed with an indwelling ange Minimum Data Set (MDS) ated R3 was cognitively intact which included benign a (BPH), obstructive uropathy, he. The MDS also indicated ive assistance of one staff for ers, dressing, toilet use, and R3's MDS further indicated the g catheter. revised 7/17/18, indicated R3 tion related to age, chair fast, etting, compromised skin Mellitus, and occasionally ler. R3's care plan further of urinary tract infections (UTI), ndwelling catheter related to ion, and prostate cancer. The staff to complete catheter care heter secure to decrease risk catheter bag below level of catheter collection bag with	F	880	<ol> <li>1) Resident R30 and R3 now have dignity bag in place and have their catheter free floating and not touch ground. R30 and R3 will be monitou ensure that staff are properly handl catheter bag during cares.</li> <li>2) All residents with catheters were identified and also were verified to dignity bags covering their drainage which act as a buffer if the drainage were to touch the ground. All other residents catheter bags are current floating and not touching the groun</li> <li>3) Policy/procedure have been reviewed/revised and will be shared staff at an education session on September 4th, 2018. In addition, s received education regarding all of areas of concern listed by state sur at an educational session on Augus 2018 instructing to never leave a di bag touching the floor directly. Edu will include proper catheter cares, b handling, and sanitization to ensure proper infection control protocol is I followed during catheter cares.</li> <li>4)Audits on R30's and R3's dignity placement and location of drainage (not touching the floor) will be comp by DON 3 times weekly for 4 weeks Audits will also be completed on R3</li> </ol>	ing the red to ing have bags bag d. d with the veyors st 1st, rainage bag being bag bag bag bag bag bag bag bag	

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# PRINTED: 08/31/2018

STATEMEN	OF DEFICIENCIES	K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	X3) DATE SURVEY COMPLETED	
			A. BUILDIN	G	CON		
			B. WING			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	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 880	back with his eyes lowest position, aga mat was on the floo tube was observed footboard and the v followed to the floo bag was observed side of the bag with the floor. No cover At 9:36 a.m. nursin R3's room to assist washed her hands R3's bed and bega and catheter tubing remained lying flat the opening spout o 9:49 a.m. NA-A sta emptying his bladd went into R3's bath graduated cylinder, wipe and returned to paper towel directly footboard and place paper towel. NA-A and grabbed the cat footboard and pulle off of the floor. As N the light yellow urin flowed back up the body. NA-A confirm had laid directly on stated the catheter stored in a plastic to basin was noted in down next to the cy	age 18 closed. His bed was in the ainst a wall, and a maroon fall or next to the bed. A catheter between the end of the R3's wall. The catheter tubing was r where a catheter drainage lying flat on the floor with the n the opening spout resting on was observed on the bag. g assistant (NA)-A entered thim with morning cares. NA-A and donned gloves, raised n washing R3's perineal area g. R3's catheter drainage bag on the floor with the side with resting directly on the floor. At ted R3 had a problem er and used a catheter. She room, obtained a plastic a paper towel, and an alcohol to R3's bed. NA-A placed the y on the floor near R3's ed the plastic cylinder onto the then reached over R3's legs atheter tubing near the ed the catheter drainage bag NA-A pulled up on the tubing, e with white fibrous sediment catheter tubing towards R3's ned the catheter drainage bag the floor on it's face and drainage bag was usually pasin on the floor. No plastic R3's room. NA-A then bent vinder on the paper towel and ge bag spout and emptied the	F 88	0 R3's catheter cares to ensinfection control protocol is 3 times weekly for four we then be reported to QA to frequently following that 4 Audits will also be complet times weekly on random re- indwelling catheters to che bag placement and locatio bag for 4 weeks. Audits wi conducted on random resi- cares 3x weekly for 4 wee proper infection control pro- followed. These audits sho problem is not recurring TI also be reported to QA to o appropriate amount of auo- the practice is sustained g	s being followed eks. Results will determine how week period. ted by DON 3 esidents with eck for dignity on of drainage II also be dents catheter ks to ensure blocol is being buld ensure the hose results will determine lits to ensure		

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		& MEDICAID SERVICES	(X2) MET	PLE CONSTRUCTION		. 0938-039 E SURVEY
		A. BUILDING			IPLETED	
		245231	B. WING _		07/	26/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSI	PITAL		30 SOUTH BEHL STREET APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 880	onto the floor. NA-/ with an alcohol wip the catheter draina using the attached emptied the urine in cylinder and grabbo it in water and return NA-A bent near the wiped them up usin placed the towel in other dirty linen, ret her hands. At 10:08 a.m. NA-/ with NA-B to assist power wheelchair. drainage bag off of to the mechanical st transferring the dra urine fell from the of floor. NA-A and NA power wheelchair. off of the mechanic onto R3's power wh NA-A if R3 had a d conceal a urine dra dignity purposes ar infection control pu one a long time age while. NA-A and NA dignity bag, but one room pushing out t R3's room leaving directly on R3's pow between his shoes observed to clean t R3's floor. At 10:22	A wiped the drainage bag spout e, closed the spout and hung ge bag on to the footboard plastic hook. NA-A then not the toilet, rinsed the ed a cloth hand towel, soaked rined to the end of R3's bed. e spilled areas of urine and ing the towel with water. NA-A a plastic garbage bag with moved her gloves and washed A left R3's room and returned ther with transferring R3 to his NA-B grabbed R3's catheter the footboard and attached it stand for the transfer. While the towel with it can be a stand for the transfer. While the towel with gloves of drainage bag multiple drops of drainage spout directly onto the a-B then transferred R3 to his NA-A took R3's drainage bag cal lift and placed it directly heelchair footrest. NA-B asked ignity bag (a bag used to alinage bag used for resident ind also acts as a barrier for irposes). NA-A stated R3 had o and has not seen it in a A-B looked in R3's room for a e was not found. NA-B left R3's he mechanical stand. NA-A left the catheter drainage bag lying wer wheelchair footrest . Neither NA-A or NA-B were the multiple drops of urine on a.m. NA-A returned to R3's colored dignity bag and	F 88			

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	-	AND HUMAN SERVICES				FORM	08/31/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245231	B. WING _			<b>07</b> /2	26/2018
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE		
APPLETON MUNICIPAL HOSPITAL					) SOUTH BEHL STREET PPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 880	Continued From pa	ae 20	F 88	30			
		e drainage bag inside of the					
	assisting him with n drainage bag laid d foot end of the bed. bag on the floor, pic footboard using the stated the drainage prior and was move bed. A plastic basin was not observed of On 7/26/18, at 9:35 (TMA)-A stated cat	a.m. NA-A was in R3's room morning cares. R3's catheter lirectly on the floor near the . NA-A looked at the drainage cked it up, and placed it on the e attached plastic hook. NA-A e bag was on the footboard ed due to R3 moving around in n for holding the drainage bag on the floor or in R3's room.					
	control concerns. T should be hooked t in place, but R3's b when occupied, so	MA-A indicated drainage bags to the bed frame to keep them bed was kept in the low position staff would use a plastic basin ge bag in to keep it off of the					
	(RN)-A stated cather never touch the floor concerns. RN-A ind bag should be hung his bed was lowere touch the floor. RN- practice was to use	A1 a.m. registered nurse eter drainage bags should or due to infection control dicated R3's catheter drainage g by the bed frame, but when ed the drainage bag would -A stated that staff's normal e pillow cases to create a e catheter drainage bag and					
	(DON) stated R3 har risk for infection, an	' p.m. director of nursing ad a history of UTIs and was at nd developing another UTI. er drainage bags should not be					

If continuation sheet Page 21 of 28

	D PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			B. WING		07		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		/26/2018	
APPLETON MUNICIPAL HOSPITAL				30 SOUTH BEHL STREET APPLETON, MN 56208			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 880		ge 21 due to infection control issues of the catheter drainage bag.	F 8	80			
	R30 was cognitively which included neurogenic bladder diabetes. The MDS extensive assistance toilet use, personal assistance of one for MDS also indicated indwelling catheter. R30's care plan rev was at risk for infect disease (renal disease community living se indwelling/intermitte plan indicated R30 related to flaccid bla staff to provide cath catheter bag and tu bladder, away from likes catheter tubing During observations was in her room se catheter tubing ran the way to the floor bag was observed b with the opening sp and was not covered	S dated 6/12/18, indicated y intact and had diagnoses , bladder disorder and also indicated R30 required ee of one staff for dressing, hygiene and limited or bed mobility and transfers. R30 required the use of an ised on 6/27/18, indicated R30 tion related to age, chronic ases, congestive heart failure), etting, diabetes mellitus, ent catheterization. R30's care had an indwelling catheter adder. The care plan directed heter care twice daily, position bing below the level of the entrance of door and when up g going down left leg. s on 7/23/18 at 2:13 p.m. R30 ated in a brown recliner, R30's directly down her left leg all where the catheter drainage ying directly on the tile flooring out resting directly on the floor id. R30's catheter tubing and right yellow urine noted. R30					

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		AND HUMAN SERVICES			FORM	08/31/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245231	B. WING		07/:	26/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSF	יITAL		80 SOUTH BEHL STREET APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 880	company in her roo could cover it with s During observation R30's was seating if R30's catheter tubin leg all the way to th drainage bag was of tile flooring with the on the floor and wa tubing and drainage it. During observations was seated in her r R30's catheter tubin leg all the way to th drainage bag was of tile flooring, spout of R30's catheter tubin bright yellow urine i -at 1:52 RN-A enter R30's catheter drain tile flooring face do R30's catheter tubin bright yellow urine i catheter bag lying of hung it on the side confirmed the abov needed assistance cares and activities indicated R30's cath be lying directly on something around i RN-A stated this wa and dignity. RN-A in residents are in the	om and stated "I wish they something." on 7/24/18 at 10:40 a.m. in her recliner in her room. ng ran directly down her left ie floor where the catheter observed lying directly on the e opening spout resting directly is not covered. R30's catheter e bag had bright yellow urine in s on 7/26/18 at 1:50 p.m. R30 ecliner in her room sleeping. ng ran directly down her left ie floor where the catheter observed lying directly on the down and was not covered. ng and drainage bag had	F 880			

Facility ID: 00655

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	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245231	B. WING		07/2	26/2018
NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
APPLETC	ON MUNICIPAL HOSP	PITAL		30 SOUTH BEHL STREET APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 880	Continued From pa	ge 23	F 8	80		
F 943 SS=B	On 7/25/18 at 9:38 in her room, staff wi drainage bag rest o not cover it. R30 ind when she has had o just laying on the flo on the garbage can On 7/26/18 at 4:23 needed staff assista use of indwelling ca assistance with cath catheter drainage b going on a surface of The DON also conf the catheter bags for case she has visitor expectations of staff the catheter drainage need to do a better Review of facility po Urinary revised on 7 of this procedure is associated urinary the control: use standard or manipulating the clean technique wh the catheter tubing the floor. Abuse, Neglect, and CFR(s): 483.95(c) Abuse, for	a.m. R30 verified when she's ill just let her catheter n the floor full sometimes and dicated it was embarrassing company in her room and its oor or hang her catheter bag p.m. DON confirmed R30 ance with ADL's, utilized the theter and needed neter cares. DON verified ags need to be covered if due to infection control issues. irmed staff should be covering or dignity issues as well in rs. The DON indicated his f would be to have them cover ge bags and indicated staff job with this on skills day. blicy titled, Catheter Care 7/2018, indicated the purpose to prevent catheter tract infections. under infection rd precautions when handling drainage system, maintain en handling or manipulating , or drainage bag and be sure and drainage bag are kept off d Exploitation Training	F 94			9/4/18

PRINTED: 08/31/2018

		& MEDICAID SERVICES	r		OMB NO. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245231	B. WING _		07/26/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	
APPLET	ON MUNICIPAL HOSF	PITAL		30 SOUTH BEHL STREET APPLETON, MN 56208	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 943	facilities must also p that at a minimum e §483.95(c)(1) Activi neglect, exploitation resident property as §483.95(c)(2) Proce of abuse, neglect, e misappropriation of §483.95(c)(3) Demo resident abuse prev This REQUIREMEN by: Based on interview facility failed to prov on resident Alzheim training including de 5 employees (E2, E dementia care train failed to provide the training on resident employees (E1) re- adult (VA) training. Findings include: The Appleton Area	provide training to their staff educates staff on- ities that constitute abuse, n, and misappropriation of s set forth at § 483.12. edures for reporting incidents exploitation, or the resident property entia management and	F 94	<ul> <li>43</li> <li>1) Alzheimer's disease and training to dementia manag completed by employees E2 and E6 by September 7th th Learning. Annual training o abuse prevention for E1 will by September 7th with Soci Designee.</li> <li>2) HR will assess all employ ensure annual training rega Alzheimer's disease and rel including dementia manage September 4th, 2018. Policy reviewed and updated to re hires will not be able to star</li> </ul>	ement will be 2, E3, E4, E5, nrough Net n resident be completed al Service yee records to rding ated training ment by y has been flect that new
	Services and Care Residents' needs-M behavior-Manage th medication-related symptoms and behavior interventions to help issues such as dea	we offer Based on our Iental Health and ne medical conditions and issues causing psychiatric avior, identify and implement o support individuals with ling with anxiety, care of itive impairment, care of		<ul> <li>a) Process for annual training hire training has been review determined that new hire training Alzheimer's disea</li> </ul>	npleted the elated training t training. ng and new wed and aining

Facility ID: 00655

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245231	B. WING		07/	26/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		20/2010
	ON MUNICIPAL HOSE	PITAL		30 SOUTH BEHL STREET APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
F 943	traumatic stress dis diagnoses, intellect disabilities. Further boarding process tr needs, the complex individual needs an exploitation. Activiti neglect, exploitation resident property, p incidents of abuse, misappropriation of care/management resident abuse prev On 7/25/18, the fol records were review - E2, hired as a die -E3, hired as a die -E3, hired as a die -E5, hired as a nurs -E6, hired as a nurs All five employee re dementia training h On 7/25/18, at 10:0 (DON) identified the not received trainin Alzheimer or deme the all staff yearly e completed next we receive the training indicated new staff without training for	Pression, trauma/PTSD (post sorder), other psychiatric sual or developmental the assessment listed the rains our staff on each resident kity of our residents is in their ad abuse, neglect and es that constitute abuse, n and misappropriation of procedures for reporting neglect, exploitation and for person with dementia and vention. lowing employee education wed: etary aid on 6/27/18. sing assistant on 4/26/18. tary aid on 5/30/18. ng assistant on 3/14/18. sing assistant on 3/12/18. ecords lacked documentation ad been completed. lowing employee education wed: etary aid on 5/30/18. ng assistant on 3/12/18. ecords lacked documentation ad been completed. lo .am. the director of nursing e newly hired facility staff had g on care of residents with ntia care. The DON identified education was set to be ek and the new staff would at that time. The DON were not typically working this length of time, however; y practice did not include	F 94	<ul> <li>training to dementia material (through Net Learning) aprevention will be completed on a prevention of the prevention will be completed to the prevention of the prevention of the prevention of the and Abuse prevention of the and Abuse prevention of the allowed to work of training has been completed on a year by January 1st of the net not be allowed to work of training has been completion before their floor) 3 months and rep HR will continue to more and employees for both new hire trainings as policy state issue does not recur. F be determined by QA contained by January 1st of the prevention and employees for both new hire training to dement to ensure yearly Alzheir related training to dement to ensure yearly Alzheir related training to dement to any prevent to QA. It is be not prevent to the prevent of the preve</li></ul>	and abuse leted by all new lay on the floor. All impleted annual imer's disease and entia management each year. If it is rly basis signified ew year, staff will on the floor until leted. hire training start date (on the ort results to QA. hitor all new hires of completion of ell as annual s to ensure the urther action will ommittee. HR will ployees records ner's disease and entia management r the last year c, 2017. Results HR will begin rds in December ear's completion of n completed and in compliance. If annual by January ill not be allowed to	

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY
		245231	B. WING		·	07/	00/0010
NAME OF	PROVIDER OR SUPPLIER	240201			STREET ADDRESS, CITY, STATE, ZIP CODE	07/2	26/2018
					30 SOUTH BEHL STREET		
APPLET	ON MUNICIPAL HOSF	11AL			APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 943	indicated being awa regarding Alzheime working directly with stated, "going forwa completed."	p.m. the administrator are of the required training r's and dementia prior to h patients. The administrator ard we will have the training	FS	943			
	E1 was hired 1/17/1 transcript indicated training course sind On 7/26/18 at 4:18 confirmed all new e upon hire and all ot annually. The DON training via Net Lea received VA training 1/17/18. The DON i turn over human re education fell throug indicated the facility education and to m getting done. The D they would be mon the education has b on the floor. Review of facility po Mistreatment and M Property revised on training component Requirements-it is t	18. E1's Net Learning E1 had not completed a VA be she was hired by the facility. p.m. director of nursing (DON) employees receive VA training her employees are trained verified all staff receive online training and verified E1 had not g since she was hired on indicated with all the employee sources indicated the gh the cracks. The DON y needed to monitor the ake sure the education was DON indicated in the future hitoring this and making sure been given before staff work					

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		AND HUMAN SERVICES					FORM	08/31/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		245231	B. WING	i			07/2	26/2018
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD	Ξ		
APPLET	ON MUNICIPAL HOSP	PITAL			30 SOUTH BEHL STREET APPLETON, MN 56208			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD	) BE	(X5) COMPLETION DATE
F 943	prohibition practices receive education a neglect, and abuse source, exploitation	inge 27 related to abuse and s. Staff and volunteers will about resident mistreatment, , including injuries of unknown and misappropriation of employment and annually after	F	943				

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		AND HUMAN SERVICES & MEDICAID SERVICES		Ŧ	6721271	FORM	08/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DAT	E SURVEY IPLETED
		245231	B. WING			07/	25/2018
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSE	PITAL			30 SOUTH BEHL STREET APPLETON, MN 56208		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	Ĺ	PROVIDER'S PLAN OF CORRECTIO	N	(X5) COMPLETION
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE RIATE	COMPLETION DATE
K 000	INITIAL COMMEN	TS	K	000			
	FIRE SAFETY						
	ALLEGATION OF DEPARTMENT'S A SIGNATURE AT TI PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE CATION OF COMPLIANCE.					
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS H	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN VITH YOUR VERIFICATION.					
	Minnesota Departr Fire Marshal Divisi Appleton Municipa NOT in compliance participation in Mer Subpart 483.70(a), 2012 edition of Nat Association (NFPA	Survey was conducted by the nent of Public Safety, State on. At the time of this survey, I Nursing Home was found e with the requirements for dicare/Medicaid at 42 CFR, Life Safety from Fire, and the tional Fire Protection Standard 101, Life Safety ter 19 Existing Health Care.					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO: Health Care Fire Ir	OR THE FIRE SAFETY			EPOC		
	State Fire Marshal 445 Minnesota St. St Paul, MN 55101	Division Suite 145					
	y director's or provi nically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE 08/23/201

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.

		AND HUMAN SERVICES & MEDICAID SERVICES	1			FORM A	08/27/2018 PPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION 21 - Main Building 01	(X3) DATE COMP	SURVEY LETED
		245231	B. WING			07/2	5/2018
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSF	PITAL			) SOUTH BEHL STREET PPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the defici 2. The actual, or pro 3. The name and/or responsible for comprevent a reoccurre Appleton Municipal building with a no bic constructed at 3 dif building was constructed at 3 dif building was at 3 dif building was constructed at 3 dif building was at 4 dif building was at 4 dif building was at 4 dif buildin	tate.mn.us and m@state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE ORMATION: what has been, or will be, done ency. oposed, completion date.		000			

Facility ID: 00655

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	OF DEFICIENCIES	& MEDICAID SERVICES			B NO. ( X3) DATE	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	· ·	01 - MAIN BUILDING 01		LETED
		245231	B. WING		07/2	5/2018
AME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PPLET	ON MUNICIPAL HOSE	PITAL		0 SOUTH BEHL STREET PPLETON, MN 56208		
(X4) ID PREFIX T <b>A</b> G	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE IATE	(X5) COMPLETIC DATE
K 000	Continued From pa	-	K 000			
K 211	The requirement at NOT MET as evide Means of Egress -		K 211			8/23/18
	CFR(s): NFPA 101 Means of Egress - General		11211	1		
	exit locations, and with Chapter 7, and continuously maint full use in case of e 18/19.2.2 through 18.2.1, 19.2.1, 7.1. This REQUIREME by: Based on observa	10.1 NT is not met as evidenced tion and interview, the facility		There have been floor decorations		
	the requirements of Code" 2012 edition This deficient pract residents, as well a staff, and visitors.	it corridors that did not meet f NFPA 101 "The Life Safety , sections 7.1.10 and 19.2.1. ice could affect 15 of 50 as an undetermined number of		to rooms 236 and 238 in the Care C North corridor. Our Care Center DC address this and make sure that the removed by 9/1/2018. Our facility manager, CFO, and CNA will make this task is completed by 9/1/2018 a DON will make sure there will be no	ON will ese are sure and the	
	07/23/2018, observ	ween 1:00 p.m. to 4:00 p.m. on vations revealed that the floor corridor next to rooms 236 and		floor decorations in the future.		
	This deficient cond Environmental Ser Exit Signage CFR(s): NFPA 101	itions was confirmed by the vices Manager.	K 293			8/23/18
	Exit Signage 2012 EXISTING Exit and directiona					

Facility ID: 00655

		E & MEDICAID SERVICES		E CONSTRUCTION	OMB NO. (X3) DATE	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		01 - MAIN BUILDING 01		PLETED
		245231	B. WING		07/2	5/2018
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON MUNICIPAL HOS	PITAL		0 SOUTH BEHL STREET APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIOI DATE
К 311	also served by the 19.2.10.1 (Indicate N/A in on with less than 30 of travel is obvious.) This REQUIREME by: Based on observa facility failed to pro as required in The 2012 edition section condition could aff residents and an u and visitors. Findings include: On the facility tour on 07/23/2018 obs revealed two Exit S in the lower level r This deficient cond Environmental Set Vertical Openings CFR(s): NFPA 107 Vertical Openings 2012 EXISTING Stairways, elevato shafts, chutes, and between floors are having a fire resist An atrium may be 19.3.1.1 through 1	10 with continuous illumination emergency lighting system. e-story existing occupancies occupants where the line of exit ENT is not met as evidenced ations and staff interview the operly identify an exterior door Life Safety Code NFPA 101 on 7.10.8.3. This deficient ect the exiting of 5 of the 50 indetermined amount of staff between 1:00 pm to 4:00 pm servations and staff interview Signs that were not illuminated ehab. ditions was confirmed by the rvices Manager. - Enclosure r shafts, light and ventilation d other vertical openings e enclosed with construction tance rating of at least 1 hour. used in accordance with 8.6.	К 293 К 31 <sup>-</sup>	Two Exit Signs on the lower leve were not illuminated. Our facility will make sure that this issue is fi the Exit Signs are properly workir 9/1/2018. The CFO and CNO wi with facility manager to ensure th completed by 9/1/2018.	manager xed and ng by Il review	8/23/18

Facility ID: 00655

If continuation sheet Page 4 of 16

					OMB NO.	SURVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	6 01 - MAIN BUILDING 01		PLETED
		245231	B. WING			25/2018
AME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PPLET	ON MUNICIPAL HOSI	PITAL		30 SOUTH BEHL STREET APPLETON, MN 56208		
(X4) ID PREFIX T <b>A</b> G	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
K 311		-	K 31 <sup>,</sup>	1		
	facility failed to ma accordance NFPA deficient practice of	tion and staff interview the intain the stairshaft in 101 (2012 edition) 7.1.1. This ould affect the exiting of all an undetermined amount of en area.		The stairwell had items stored facility manager will make sure items are moved by 9/1/2018. manager will also continue to continue location to make sure nothing the stairwell in the future. The CNO will review with facility may ensure this task is completed by	that these The facility observe this s stored in CFO and anager to	
	on 07/23/2018 obs	between 1:00 pm to 4:00 pm ervations and staff interview red in the stair well near the				
	This deficient cond Environmental Ser Hazardous Areas CFR(s): NFPA 101	- Enclosure	K 32	1		8/23/18
	having 1-hour fire fire rated doors) of system in accorda When the approve system option is u separated from oth partitions and doo Doors shall be sel and permitted to h protective plates th from the bottom of	are protected by a fire barrier resistance rating (with 3/4 hour r an automatic fire extinguishing nce with 8.7.1 or 19.3.5.9. ed automatic fire extinguishing sed, the areas shall be her spaces by smoke resisting rs in accordance with 8.4. f-closing or automatic-closing ave nonrated or field-applied hat do not exceed 48 inches f the door. and zone locations of			¢	

Facility ID: 00655

If continuation sheet Page 5 of 16

		AND HUMAN SERVICES & MEDICAID SERVICES			FOI	RM AI	08/27/2018 PPROVED 938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY ETED
		245231	B. WING			07/25	5/2018
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSF	PITAL			SOUTH BEHL STREET PPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 321	Continued From pa 19.3.2.1, 19.3.5.9		ĸ	321			
	b. Laundries (larger c. Repair, Maintena d. Soiled Linen Roo e. Trash Collection (exceeding 64 gallo f. Combustible Stor (over 50 square fee g. Laboratories (if of Hazard - see K322 This REQUIREME by: Based on observa facility failed to mai room and one com accordance with th (NFPA 101) section condition could allo corridor making it u and efficient exiting an undetermined a	Fired Heater Rooms r than 100 square feet) ance, and Paint Shops oms (exceeding 64 gallons) Rooms ons) rage Rooms/Spaces et) classified as Severe			The oxygen room in the west corridor no longer smoke resistant and also do not have a closer. The facility manage will make sure a proper door and close installed by 10/1/2018. The CFO and CNO will review with facility manager to ensure this task is completed by 10/1/2018.	es r eris	
	on 07/23/2018 obs revealed the Oxyge was not properly se resistant and did ne						
K 341 SS=D	Environmental Ser Fire Alarm System	- Installation	к	341			8/23/18

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Facility ID: 00655

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORMA	08/27/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION 11 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY PLETED
		245231	B. WING			07/2	5/2018
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 30 SOUTH BEHL STREET				
APPLET	ON MUNICIPAL HOSP	PITAL		30 Al			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 341	Continued From pa	ge 6	KS	341			
1	components approv accordance with NF and NFPA 72, Natio provide effective wa building. In areas n detection is installe unit. In new occupa at notification applia and supervising sta	is installed with systems and ved for the purpose in FPA 70, National Electric Code, onal Fire Alarm Code to arning of fire in any part of the ot continuously occupied, d at each fire alarm control ancy, detection is also installed ance circuit power extenders, ation transmitting equipment. wiring or other transmission d for integrity.					
	by: Based on observat facility failed to inst accordance with NI (2012) section 19.3 National Fire Alarm This deficient pract the alarm system to during a fire event residents and an u and visitors. Findings include: On the facility tour on 07/23/2018 obse revealed a smoke of	NT is not met as evidenced tions and staff interview the all the smoke detection in FPA 101 Life Safety Code 8.4.1, 9.6.1.3 and NFPA 72 Code (2010) section 17.7.4.1. ice could affect the ability of o sound in a timely manner which could affect 5 of the 50 indetermined amount of staff between 1:00 pm to 4:00 pm ervations and staff interview detector with 36 inches of an e lower level rehab.			The smoke detector when installer placed to close to the HVAC vent i lower level rehab. Our facility mar will relocate this smoke detector b 9/1/2018. The CFO and CNO will with facility manager to ensure this completed by 9/1/2018.	n the nager y review	

If continuation sheet Page 7 of 16

PREPX TAC       Texture Deriver on Set intermining information       PREPX TAC       CARSE-REFERENCE TO THE APPROPRIATE DEFICIENCY       Date         K 341       Continued From page 7 This deficient condition was confirmed by the Environmental Services Supervisor.       K 341       K 341         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 System section and testing are maintenance, inspection and testing are maintained in a secure location and readily available.       K 353         B       Other System Isst checked       Diverse System for the approximation on coverage for any non-required or partial automatic sprinkler system.       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 This RECUIREMENT 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 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.       The sprinkler heads in the dining room were covered in lint and there is a hole in the celling in the lower level by the electrical room. The facility manager will review with facility manager to celling the sepalaced by 9/1/2018. The CFO and CNO will review with facility manager to ensure this task is completed by 9/1/2	OLIVITIE OF THE OF INCLEASE INFORMATION OF CORRECTION IN COMPLETE CONSTRUCTION       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION       (X3) DATE SURV.         AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION       A. BUILDING 01       (X3) DATE SURV.         NAME OF PROVIDER OR SUPPLIER       245231       B. WING       07/25/20         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       30 SOUTH BEHL STREET       APPLETON, MN 56208         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION SHOULD BE       (CACH DEFICIENCY MUST BE PRECEDED BY FULL         TAG       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION SHOULD BE       (CACH DEFICIENCY MUST BE PRECEDED BY FULL         TAG       SUMMARY STATEMENT OF DEFICIENCIES       ID       PREFIX       TAG       PROVIDER'S PLAN OF CORRECTION SHOULD BE       (CACH CORRECTIVE ACTION SHOULD BE         (X4) ID       EACH DEFICIENCY WIST BE PRECEDED BY FULL       TAG       PROVIDER'S PLAN OF CORRECTION SHOULD BE       (CACH CORRECTIVE ACTION SHOULD BE       (CACH CORRECTIVE ACTION SHOULD BE         (X4) ID       EENVIRONMENTAL SERVICES SUPERVISOT.       K 341       K 341       STREET ADDRESS, ITY, STATE, ZIP CODE       (CACH CORRECTIVE ACTION SHOULD BE         SSS=F       CFR(s): NFPA 101       K 341<	DEPART	MENT OF HEALTH	AND HUMAN SERVICES		P		08/27/2018 APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       [V1] DEPUTIFICATION NUMBER       [V2] DATE SUPPLYEY A DULINING 01 - MAIN BUILDING 01       [V2] DATE SUPPLYEY COMPLETED       [V2] DATE SUPPLYEY A DULINING 01 - MAIN BUILDING 01       [V2] DATE SUPPLYEY COMPLETED       [V2] DATE SUPPLYEY COMPLETED         APPLETON MUNICIPAL HOSPITAL       STREET ADDRESS CITY, STATE J2P CODE 30 SOUTH BEHL STREET APPLETON, MUSICIPAL HOSPITAL       [V2] DATE SUPPLYEY SUPPLETON, MIN 65208       (V2) 30 SOUTH BEHL STREET APPLETON, MIN 65208         (X4] ID PRETIX MG       Continued From page 7 This deficient condition was confirmed by the Environmental Services Supervisor.       [X] 341 K 343       [X] 341 Continued From page 7 This deficient condition was confirmed by the Environmental Services Supervisor.       [X] 353 SEF CFR(s): NFPA 101       [X] 353 Service Suppervisor.       [X] 353 Service Critical Condition could coordance with NFPA 25, Standard for the Inspection and testing are maintained in a secure location and readily available.       [X] 364 Service Suppervisor.       [X] 353 Service Suppervi	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01       (X3) DATE SURV. COMPLETE         NAME OF PROVIDER OR SUPPLIER       245231       B. WING       07/25/20         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE 30 SOUTH BEHL STREET APPLETON MUNICIPAL HOSPITAL       STREET ADDRESS, CITY, STATE, ZIP CODE 30 SOUTH BEHL STREET APPLETON, MN 56208       07/25/20         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH ORFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORFICE TVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       000000000000000000000000000000000000	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		C	MB NO.	0938-0391
NAME OF PROVIDER OR SUPPLER     STREET ADDRESS, CITY, STATE 2/P CODE 30 SOUTH BEHL STREET       APPLETON MUNICIPAL HOSPITAL     STREET ADDRESS, CITY, STATE 2/P CODE 30 SOUTH BEHL STREET       (%4) ID PROVIDERS PLAND, TAG     STREET ADDRESS, CITY, STATE 2/P CODE 30 SOUTH BEHL STREET       (%4) ID PROVIDERS PLAND, TAG     STREET ADDRESS, CITY, STATE 2/P CODE 30 SOUTH BEHL STREET       (%4) ID PROVIDERS PLAND, TAG     STREET ADDRESS, CITY, STATE 2/P CODE 30 SOUTH BEHL STREET       (%4) ID PROVIDERS PLAND, TAG     STREET ADDRESS, CITY, STATE 2/P CODE 30 SOUTH BEHL STREET       (%4) ID PROVIDERS PLAND, TAG     STREET ADDRESS, CITY, STATE 2/P CODE 30 SOUTH BEHL STREET       (%4) ID PROVIDERS PLAND, STREET ADDRESS, CITY, STATE 2/P CODE 30 SOUTH BEHL STREET ADDRESS, CITY, STATE 2/P CODE 30 SOUTH BEHL STREET ADDRESS, CITY, STATE 2/P CODE 30 SOUTH BEHL STREET 30 SOUTH BEHL STREET 30 SOUTH BEHL STREET 30 SOUTH BEHL STREET 30 SOUTH STATE 30 SOUTH BEHL STREET 30 SOUTH STATE 30 SOUTH ST	NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         APPLETON MUNICIPAL HOSPITAL       STREET ADDRESS, CITY, STATE, ZIP CODE         (X4) ID PREFIX       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 OERICIENCY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH OERICIENCY)       COM COM COM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         K 341       Continued From page 7 This deficient condition was confirmed by the Environmental Services Supervisor.       K 341         S 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.       K 353	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
APPLETON MUNCIPAL HOSPITAL         30 SOUTH BEHL STREET APPLETON, MN 56208           (A) ID PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG         ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG         ID PREFIX TAG         PREFIX (EACH DORREST ILAN OF CORRECTION (EACH DORRECTION) (EACH DORREST ILAN OF CORRECTION (EACH DORRECTION) (EACH DORREST ILAN OF CORRECTION (EACH DORRECTION) (EACH DORREST ILAN OF	30 SOUTH BEHL STREET APPLETON, MN 56208         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH OERECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COME COME         K 341       Continued From page 7 This deficient condition was confirmed by the Environmental Services Supervisor.       K 341       K 341       K 341       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 maintenance, inspection and testing are maintenance, inspection and testing are maintenance in a secure location and readily available.       8/23			245231	B. WING _		07/2	25/2018
APPLETON MUNICIPAL HOSPITAL       APPLETON, MN 56208         (M) D PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BLE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PROVIDENS PLAN OF CORRECTION A CROSS-HEEPENEDTO THE APPROPRIATE DEFICIENCY       COMPLET (CROSS-HEEPENEDTO THE APPROPRIATE DEFICIENCY       CROSS-HEEPENEDTO THE APPROPRIATE DEFICIENCY       COMPLET (CROSS-HEEPENEDTO THE APPROPRIATE DEFICIENCY       CROSS-HEEPENEDTO THE APPROPRIATE DEFICIENCY       CROSS-HEEPENEDTO CROSS-HEEPENEDTO THE APPLETON THE APPLICENCY       THE STITUE THE APPLETON THE APPLETON THE APPLETON THE APPLETON THE APPLETON THE APPLETON THE APPLETON THE APPLETON THE APPLETON THE APPLETON THE APPLETON THE APPLETON THE APPLETON THE APPLETON THE APPLETON THE APPLETON THE AP	APPLETON MUNICIPAL HOSPITAL       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 CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COME         K 341       Continued From page 7 This deficient condition was confirmed by the Environmental Services Supervisor.       K 341       K 341         SS=F       CFR(s): NFPA 101       K 353       K 353         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.       Altomatic sprinkler and standpipe systems are inspected.       8/23	NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
Mail Trag       CEACH CORRECT A CONSTRUCT A DEPROCEMENT ON SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY       COMMETTEE APPROPRIATE       Commetee Approprindin the Appropriate       Commettee	(A) ID PREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)COME COMEK 341Continued From page 7 This deficient condition was confirmed by the Environmental Services Supervisor.K 341K 341SS=FCFR(s): NFPA 101K 353K 3538/23Sprinkler 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, maintained in a secure location and readily available.8/23	APPLET	ON MUNICIPAL HOSE	PITAL				
This deficient condition was confirmed by the Environmental Services Supervisor.       K 353       8/23/18         K 353       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.       The sprinkler heads in the dining room were covered in lint and there is a hole in the coiling in the lower level by the electrical room. The facility manager will review proper cleaning schedule with housekeeping to make sure sprinkler heads are ceilang. 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.       The comparison of the CPO and CNO will review with facility manager to ensure this tak is completed by 91/12018.	This deficient condition was confirmed by the       Environmental Services Supervisor.       8/23         K 353       Sprinkler System - Maintenance and Testing       K 353         SS=F       CFR(s): NFPA 101       K 353         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.       Bis and the secure location and readily available.	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETION
K 353       Sprinkler System - Maintenance and Testing       K 353       8/23/18         SS=F       CFR(s): NFPA 101       Sprinkler System - Maintenance and Testing       K 353       8/23/18         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, 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 maintainatin 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 to to function properly and allow for the spread of fire. This could affect an undetermined amount of residents, staff and visitors.       The Sprinkler heads in the dining room with facility manager will also make sure the ceiling the is replaced by 9/1/2018. The CFO and CNO will review with facility manager to ensure this tak is completed by 9/1/2018.	K 353       Sprinkler System - Maintenance and Testing       K 353       8/23         SS=F       CFR(s): NFPA 101       K 353       8/23         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.       8/23	K 341	This deficient cond	ition was confirmed by the	K 34	1		
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.	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.		Sprinkler System -		K 35	53		8/23/18
c) Water system supply sourceProvide 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.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 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.			Automatic sprinkler inspected, tested, a with NFPA 25, Star Testing, and Mainta Protection Systems maintenance, inspe- maintained in a sec available.	r and standpipe systems are and maintained in accordance indard for the Inspection, aining of Water-based Fire s. Records of system design, ection and testing are cure location and readily				
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.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.				-				
Finangs include.	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.		Provide in REMAR any non-required o system. 9.7.5, 9.7.7, 9.7.8, This REQUIREME by: Based on observa facility failed to ma accordance with th (NFPA 101) and NI standard for testing systems. This defic sprinkler system no allow for the sprea- undetermined amo visitors.	KS information on coverage for or partial automatic sprinkler and NFPA 25 NT is not met as evidenced ition and staff interview, the intain the sprinkler system in the 2012 Life Safety Code FPA 25 section 5.2.1.1.2. The g and maintenance of sprinkler cient condition could cause the ot to function properly and d of fire. This could affect an		were covered in lint and there is a the ceiling in the lower level by th electrical room. The facility mana review proper cleaning schedule housekeeping to make sure sprin heads are clean. Facility manage also make sure the ceiling tile is by 9/1/2018. The CFO and CNO review with facility manager to en	a hole in e ager will with hkler er will replaced will	

Facility ID: 00655

If continuation sheet Page 8 of 16

		& MEDICAID SERVICES				), 0938-039 TE SURVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION 6 01 - MAIN BUILDING 01		MPLETED
		245231	B. WING		07	//25/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSE	PITAL		30 SOUTH BEHL STREET APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 353	Continued From pa	age 8	K 35	3		
	on 07/23/2018 obs revealed 4 sprinkle dining room and a	between 1:00 pm to 4:00 pm ervations and staff interview r heads covered in lint in the hole in the ceiling tile in the across from the electrical				
K 363	This deficient condition was confirmed by the Environmental Services Supervisor. Corridor - Doors CFR(s): NFPA 101		K 36	3		8/23/18
	required enclosure hazardous areas re and are made of 1 wood or other mate at least 20 minutes smoke compartment the passage of sm to rooms containin materials have pos latches are prohibi requirements do n do not contain flam Clearance betwee covering is not exe complying with 7.2 with a device capa when a force of 5 1 impediment to the devices that releas pulled are permitte of unlimited height	orridor openings in other than s of vertical openings, exits, or esist the passage of smoke 3/4 inch solid-bonded core erial capable of resisting fire for s. Doors in fully sprinklered ents are only required to resist oke. Corridor doors and doors g flammable or combustible sitive latching hardware. Roller ted by CMS regulation. These of apply to auxiliary spaces that mable or combustible material. In bottom of door and floor eeding 1 inch. Powered doors .1.9 are permissible if provided ble of keeping the door closed bf is applied. There is no closing of the doors. Hold open se when the door is pushed or ed. Nonrated protective plates are permitted. Dutch doors is are permitted. Door frames				

Facility ID: 00655

If continuation sheet Page 9 of 16

		AND HUMAN SERVICES & MEDICAID SERVICES		FC	ED: 08/27/201 RM APPROVE NO: 0938-039
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	E CONSTRUCTION (X3)	DATE SURVEY COMPLETED
		245231	B, WING		07/25/2018
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
APPLET	ON MUNICIPAL HOSE	PITAL		0 SOUTH BEHL STREET APPLETON, MN 56208	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION E DATE
	smoke compartme window assemblies sprinklered compar restrictions in area frames in window a 19.3.6.3, 42 CFR F and 485 Show in REMARKS protection ratings, a etc. This REQUIREME by: Based on observa facility failed to pro- means suitable for resist the passage the 2012 Life Safet 19.3.6.3.1 & 19.3.6 could allow for smo making it difficult to affecting 24 of the undetermined amo Findings include: On facility tour betw 07/23/2018, it was kitchen corridor wa resist the passage rating. This deficient conce Environmental Ser Subdivision of Buil	ance with 8.3, unless the nt is sprinklered. Fixed fire is are allowed per 8.3. In rtments there are no or fire resistance of glass or assemblies. Parts 403, 418, 460, 482, 483, S details of doors such as fire automatics closing devices, NT is not met as evidenced tion and staff interview the vide two corridor doors with a keeping the door closed and of smoke in accordance with ty Code (NFPA 101) section 6.3.5. This deficient practice ble to enter the corridor o exit in the case of fire, 50 residents and an bunt of staff and visitors. ween 1:00 p.m. to 4:00 p.m. on observed that the door to the as damaged and would not of smoke and voids the fire	K 363	The current door in the kitchen corride damaged and needs to be replaced we proper door. The facility manager will make sure that a new door is ordered installed by 10/1/2018. The CFO and CNO will review with facility manager ensure this task is completed by 10/1/2018.	ith a and

OF DEFICIENCE		(YO) MULTER	LE CONSTRUCTION	(X3) DATE	SURVEY
OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLETED
	245231	B. WING		07/2	25/2018
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ON MUNICIPAL HOSE	PITAL				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETIC DATE
Continued From pa	age 10	K 372	2		
Construction 2012 EXISTING Smoke barriers sha fire resistance ratin be permitted to tern Smoke dampers al penetrations in fully an approved sprink smoke compartme barrier. 19.3.7.3, 8.6.7.1(1) Describe any mech in REMARKS. This REQUIREME by: Based on record r facility failed to ma accordance with T Other Opening Pro- edition section 19.4 could allow smoke compartments affer all residents and al and visitors.	all be constructed to a 1/2-hour ing per 8.5. Smoke barriers shall minate at an atrium wall. re not required in duct y ducted HVAC systems where kler system is installed for ints adjacent to the smoke manical smoke control system NT is not met as evidenced eview and staff interview the intain smoke dampers in he Standard for Fire Doors and bective's, NFPA 80, 2010 4.1.1. This deficient practice to travel throughout smoke excing the exiting capabilities of n undetermined amount of staff		is not sealed at the ceiling. The needed 2 5/8" sheet rock will be to the roof deck along the fire ba 10/1/2018. Our facility manager with the CFO and CNO will moni	additional extended rrier by along tor this	
barrier by the time sealed at the ceilin This deficient cond	clock area, east wall was not lg. dition was confirmed by the				
	vices Supervisor.	K 71	2		8/23/18
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENC) REGULATORY OR L Continued From particles Subdivision of Build Construction 2012 EXISTING Smoke barriers shafter resistance ratin be permitted to term Smoke barriers shafter resistance ratin be permitted to term Smoke dampers and penetrations in fully an approved sprink smoke compartment barrier. 19.3.7.3, 8.6.7.1(1) Describe any mech in REMARKS. This REQUIREME by: Based on record re facility failed to man accordance with To Other Opening Pro- edition section 19.4 could allow smoke compartments affer all residents and a and visitors. Findings include: On facility tour betto 07/23/2018, obser- barrier by the time sealed at the ceilin This deficient concer- Environmental Ser	245231         PROVIDER OR SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         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.	245231       B. WING         PROVIDER OR SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         Continued From page 10       K 372         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 defic	245231     B. WING       PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE 30 SOUTH BEHL STREET APPLETON, NM 56208       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREVIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PREVIX (EACH CORRECTIVE ACTION SHOUL CROSS-REPERENCED) THE APPHO DEFICIENCY MUST BE PRECED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       Continued From page 10     K 372       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.     The smoke barrier by the time c is not sealed at the ceiling. The needed 2 5/8" sheet rock will be to the roof deck along the fire bar 10/1/2018. Our facility manager with the CFO and CNO will moni progress and ensure completion 10/1/2018.       In residents and an undetermined amount of staff and visitors.     Findings include:       Prind 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.	CORRECTION       DEMINFUNCTION NOMBLEX       A BUILDING 01 - MAIN BUILDING 01         245231       B WING

Facility ID: 00655

If continuation sheet Page 11 of 16

the second s		AND HUMAN SERVICES & MEDICAID SERVICES				FORM A	08/27/2018 PPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION 11 - MAIN BUILDING 01	X3) DATE COMP	SURVEY LETED
		245231	B. WING			07/2	5/2018
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSF	PITAL			SOUTH BEHL STREET PPLETON, MN 56208		
(X4) ID PREFIX T <b>A</b> G	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE IATE	(X5) COMPLETION DATE
K 712	Continued From pa	ige 11	ĸ	712			
	signal and simulatic conditions. Fire dril unexpected times u least quarterly on e with procedures an established routine between 9:00 PM a announcement ma alarms. 19.7.1.4 through 19 This REQUIREMED by: Based on record re facility failed to pro- at least quarterly of Life Safety Code (N section 19.7.1.4 to practice could reduced conduct a safe and emergency, which an undetermined a Findings include: On facility tour betw 07/23/2018, docum Fire drills were not 1) 1st quarter 2nd 2) 2nd shift second 3) 3rd shift third qu 4) 1st and 2nd shift	NT is not met as evidenced eview and staff interview the vide documentation of fire drills n each shift as required by the NFPA 101) 2012 edition, 19.7.1.7. This deficient ace the ability of staff to 1 timely response to a fire would affect all residents and amount of staff and visitors. ween 1:00 pm and 4:00 pm on hentation reviewed revealed performed during these times: and 3rd shift of 2018 d quarter in 2018 iarter 2017 t 4th quarter of 2017 tice was verified by the			Our facility manager was not prese during the cited fire drills and did no these events properly. Facility man will be present for all required fire dr and document appropriately for eac each quarter. Our facility manager with the CFO and CNO will monitor progress and ensure completion 9/4	ot log ager rills ch shift along this	
LFORM CMS-2	567(02-99) Previous Version		21	Fa	cility ID: 00655 If continuati	on sheet	Page 12 of 16

OF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER ON MUNICIPAL HOSF	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245231	A. BUILDING C	E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
ON MUNICIPAL HOSE	245231				
ON MUNICIPAL HOSE				07/2	25/2018
			TREET ADDRESS, CITY, STATE, ZIP CODE		
SUMMARY STA	PITAL		) SOUTH BEHL STREET PPLETON, MN 56208		
(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIO DATE
Fundamentals - Bu CFR(s): NFPA 101	ilding System Categories	K 901			8/23/18
Building systems at 1 through 4 require Categories are dete documented risk as performed by qualit	re designed to meet Category ments as detailed in NFPA 99, ermined by a formal and essessment procedure fied personnel.				
by: Based on docume interview, the facilit systems are design through 4 requirem Categories are det documented risk as performed by quali	ntation review and staff y failed to inspect the building ned to meet Category 1 ents as detailed in NFPA 99. ermined by a formal and ssessment procedure fied personnel. The deficient		assessment from NFPA 99 by the this inspection. The facility managestart this immediately and this will completed by 10/1/2018. Our facil manager along with the CFO and	date of ger will be ity CNO	
on 07/23/2018, do interview revealed	cumentation review and staff the required risk assessment				
Environmental Ser Electrical Systems	vices Manager. - Maintenance and Testing	K 914			8/23/18
	CFR(s): NFPA 101 Fundamentals - Bu Building systems and 1 through 4 require Categories are dete documented risk as performed by qualit Chapter 4 (NFPA 9 This REQUIREMENT by: Based on docume interview, the facilit systems are design through 4 requirem Categories are dete documented risk as performed by qualit practice could affect staff. Findings include: On the facility tour on 07/23/2018, do interview revealed NFPA 99 had not b survey. This deficient cond Environmental Ser Electrical Systems CFR(s): NFPA 101	<ul> <li>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)</li> <li>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.</li> <li>Findings include:</li> <li>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.</li> <li>This deficient conditions was confirmed by the Environmental Services Manager. Electrical Systems - Maintenance and Testing CFR(s): NFPA 101</li> </ul>	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. Electrical Systems - Maintenance and Testing K 914	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 could affect all residents, visitors and         staff.         Findings include:         On the facility tour between 1:00 pm to 4:00 pm         on the facility tour between 1:00 pm to 4:00 pm         on T/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.         Electrical Systems - Maintenanc	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.         Electrical Systems - Maintenance and Testing CFR(s): NFPA 101

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	08/27/2018 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, .	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245231	B. WING		07/2	25/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSF	PITAL		30 SOUTH BEHL STREET APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 914	locations and where anesthesia is admin installation, replace testing is performed documented perfor listed as hospital-git tested at intervals r isolation monitors ( intervals of less that actuating the LIM to which activates bot LIM circuits with au manual test is perfor equal to 12 months 6.3.3.3.2 after any electric distribution maintained of requirepairs or modifica area tested, and re 6.3.4 (NFPA 99) This REQUIREME by: Based on record r electrical testing ar maintained in acco Standards for Heal section 6.3.4. This 50 residents as we of staff, and visitor 6.3.2.4.2 (NFPA 99) Findings include: During documenta 4:00 pm on 07/23/ be located to show	eptacles at patient bed e deep sedation or general histered, are tested after initial ment or servicing. Additional d at intervals defined by mance data. Receptacles not rade at these locations are not exceeding 12 months. Line LIM), if installed, are tested at an or equal to 1 month by est switch per 6.3.2.6.3.6, h visual and audible alarm. For itomated self-testing, this ormed at intervals less than or s. LIM circuits are tested per repair or renovation to the system. Records are ired tests and associated tions, containing date, room or sults. NT is not met as evidenced eview and staff interview, the nd maintenance was not ordance with NFPA 99 Ith Care Facilities 2012 edition, a could negatively affect 50 of ill as an undetermined number s to the facility. 6.3.2.2.6.2 (F),		4 Our facility manager failed to pro documentation of our annual elec- outlet inspection. Our facility ma ensure that this inspection is dor annually and proper documentat completed. We will complete thi 10/1/2018. Our facility manager with the CFO and CNO will moni progress and ensure completion following up with the facility mana- make sure that the task is compl 10/1/2018.	ctrical nager will ion is s by along tor this by ager and	

Facility ID: 00655

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		& MEDICAID SERVICES			3) DATE SURVEY		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X 01 - MAIN BUILDING 01	COMPLETED		
		245231	B. WING		07/25/2018		
	PROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STATE, ZIP CODE			
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K 914	Continued From pa	ige 14 ition was verified by the	K 914				
	Enviironmental Ser		K 920		8/23/18		
	Extension Cords Power strips in a pa- used for componer patient-care-related (PCREE) assemble by qualified person 10.2.3.6. Power st may not be used for electronics), excep rooms that do not u PCREE meet UL 1 strips for non-PCR (outside of vicinity) care rooms, power standards. All pow precautions. Exter substitute for fixed Extension cords us immediately upon which it was install 10.2.4. 10.2.3.6 (NFPA 99 (NFPA 70), 590.3(I This REQUIREME by: Based on observa facility failed to ensi- connection was in edition of NFPA 95 total ampacity. Thi	nt - Power Cords and atient care vicinity are only nts of movable d electrical equipment es that have been assembled nel and meet the conditions of rips in the patient care vicinity or non-PCREE (e.g., personal t in long-term care resident use PCREE. Power strips for 363A or UL 60601-1. Power EE in the patient care rooms meet UL 1363. In non-patient strips meet other UL ver strips are used with general nsion cords are not used as a wiring of a structure. sed temporarily are removed completion of the purpose for ed and meets the conditions of 0, 10.2.4 (NFPA 99), 400-8 D) (NFPA 70), TIA 12-5 NT is not met as evidenced ation and staff interview the sure a multiple outlet accordance with the 2012 9 section 10.2.3.6 item 2 for s deficient practice could cause rouit which could cause a		In our maintenance room, we have extension cord coming out of the cettile. Our facility manager will makes that this is removed by 9/1/2018. The CFO and CNO will monitor this prog and ensure completion by 9/1/2018.	iling sure ne ress		

Facility ID: 00655

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		AND HUMAN SERVICES & MEDICAID SERVICES				RINTED: 0 FORM AF MB NO: 0	PROVED
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE S COMPL	
		245231	B: WING			07/25	/2018
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSF	PITAL			SOUTH BEHL STREET PPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 920	undetermined amo Findings include: On the facility tour I on 07/23/2018 obse revealed an extens the ceiling tile in the	ct 5 of the 50 residents and an unt of staff and visitors. between 1:00 pm to 4:00 pm ervations and staff interview ion cord penetrating through e maintenance room. ice was verified by the	K	920			
EORM OME 2	567(02-99) Previous Version:	s Obsolete Event ID: HB612	01	Fac	cility ID: 00655 If continua	ition sheet P	age 16 of 16

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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: 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Appleton Municipal Hospital August 13, 2018 Page 2 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

Minnesc	ta Department of He	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00655	B. WING		07/2	6/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSF	ριται	H BEHL STR N, MN 5620			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh	nether a violation has been				
	number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	Ile number indicated below. ns several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 08/23/18
	loany orgined					00/20/10

STATE FORM

If continuation sheet 1 of 30

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00655	B. WING		07/2	26/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
APPLET	ON MUNICIPAL HOS	ριται	H BEHL STRE ON, MN 56208			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Department of Hea	age 1 alth orders being submitted to Although no plan of correction	2 000			
	is necessary for St enter the word "con text. You must ther State licensure pro completion date, th	ate Statutes/Rules, please rrected" in the box available for n indicate in the electronic ocess, under the heading ne date your orders will be electronically submitting to the				
	Department's staff the following correct Please indicate in y correction that you	18, surveyors of this , visited the above provider and ction orders are issued. your electronic plan of have reviewed these orders, te when they will be completed				
	the State Licensing federal software. T	nent of Health is documenting correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled "II statute/rule out of of "Summary Stateme and replaces the "" correction order. T findings which are after the statement evidence by." Follo	number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute t, "This Rule is not met as owing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUMI "PROVIDER'S PLA APPLIES TO FEDI	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. AR ON EACH PAGE.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00655	B. WING	B. WING		
NAME OF PRO	VIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE		
PPLETON	MUNICIPAL HOS	ριται	TH BEHL STRE TON, MN 56208			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 000 C	ontinued From pa	age 2	2 000			
PI M FC "P AI TH TH PI	LAN OF CORRECT INNESOTA STAT OURTH COLUMI PROVIDER'S PLA PPLIES TO FEDI HIS WILL APPEA HERE IS NO RECT	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES. ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 265 M		5 Notification of Chg in	2 265			8/22/18
pc ph pr leg m ac nu at de ha	blicies to guide stanysicians, physicians, physicians, and if gal representative ember of a reside ccident, or death. ursing services, a tending physician evelopment of the	ust develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's or an interested family ent's acute illness, serious At a minimum, the director of and the medical director or an must be involved in the se policies. The policies mus address at least the tion times for:				
		involving the resident which I has the potential for requiring on;	9			
ex	nysical, mental, c cample, a deterio	change in the resident's or psychosocial status, for ration in health, mental, or s in either life-threatening				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00655	B. WING	WING		26/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
APPLET	ON MUNICIPAL HOS	ριται	'H BEHL STF ON, MN 562(			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 265	Continued From pa	age 3	2 265			
	conditions or clinic	al complications;				
	example, a need to of treatment due to begin a new form o					
	D. a decision resident from the n	to transfer or discharge the ursing home; or				
	E. expected an	nd unexpected resident deaths				
	by: Based on observat review, the facility party and physiciar	ent is not met as evidenced ion, interview, and document failed to ensure the responsible n were notified timely of a tegrity for 1 of 1 resident (R25) ation of change.		Corrected		
	Findings include:					
	8/30/17, identified impairment, and ha dementia, arthritis, vision. The MDS fu able to walk, requir with all areas of da the ability to eat with Admission Record R25's family memb	linimum Data Set (MDS) dated R25 had severe cognitive ad diagnoses which included depression, and impaired urther identified R25 was not red extensive staff assistance ily living with the exception of th staff supervision. R25's printed 7/25/18, identified per (FM)-A as R25's care conference person, and y contact #1.				
	member (FM)-A ide	9 p.m. during interview, family entified a concern of poor facility staff in regards to R25's pointments.	;			

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If continuation sheet 4 of 30

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
	00655		B. WING		07/	26/2018
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
APPLET	ON MUNICIPAL HOS	ριται	TH BEHL STRE ON, MN 56208			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC		(X5) COMPLET
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO		DATE
2 265	Continued From pa	age 4	2 265			
	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 not identified the follow	tes were reviewed and ving entries:				
	completed with a.m posterior above elb Noted band-aid co lateral side below e with intact scabbed	and note: Skin assessment h. bath noted bruising to left bow measuring $3 \times 3.5 \times 0$ cm. vering bruising to left posterior elbow measuring $4.5 \times 2 \times 0$ cr d skin tear measuring $0.3 \times 0.1$ redness noted to scabbed area	n			
		d further documentation tear or bruising of the left				
	documentation of t	tment record lacked he skin tear and bruising or ents on the left elbow.				
	indicated the usual identified alteration is completed in the triggers a weekly for residents physician	2 a.m. registered nurse (RN)-A facility protocol for an in skin as follows: A skin form computer system which blow up by nursing. The and family are notified of the if necessary a wound nurse is	n			

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         00655		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		E SURVEY PLETED
		00655	B. WING			26/2018
IAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE	<u>.</u>	
PPLET	ON MUNICIPAL HOSE	ρίτδι	TH BEHL STRE TON, MN 56208			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 265	and verified the pro- which identified R2 the left elbow. RN-/ medical record and documentation was On 7/25/18, at 9:06 visualized by RN-A wound on the left e 0.7 cm. RN-A state here." On 7/25/18, at 2:51 DON) indicated the a change in conditi- 1st- Complete an ir Clean and dress th 2nd- Notify the fam The DON clarified v computer system th alert the floor nurse reviewed weekly by The facility policy ti Minor Breaks, Care under the subtitle F responsible family may be routine (the abrasion is uncomp significant trauma. The facility policy ti revised 7/2017, ide resident's condition shared with the res representative, acc	pgress noted dated 6/28/18, 5's skin tear and bruising on A further reviewed R25's I verified no further found. 6 a.m. R25's elbow was . RN-A verified R25 had a low which measured 1.3 x d, "Someone dropped the bal p.m. the director of nursing ( the usual facility protocol with on or skin alteration as follow noident form and skin form. e area appropriately. ily and the physician. with the skin form initiated the hen has pop-ups weekly to es to ensure the area is	2 265	DEFICIENC	·Υ)	

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSP	ρίτδι	TH BEHL STRE ON, MN 56208			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 265	Continued From pa	ige 6	2 265			
	available. All pertine	here are multiple care options ent information will be made vider by the facility staff.				
	DON or designee of director to update p when to notify the p resident, and then of or designee could a	THOD OF CORRECTION: The could work with the medical policies and procedures for physician of changes in the could educate staff. The DON also perform audits of resident he if the physician had been fate.				
	TIME PERIOD FOR days	R CORRECTION: Thirty (30)				
2 302	MN State Statute 1 or related disorder	44.6503 Alzheimer's disease train	2 302			8/22/18
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144					
	Alzheimer's disease or related o segregated or gene care staff	lity serves persons with disorders, whether in a eral unit, the facility's direct rs must be trained in dementia	a			
	related disorders; (2) assistance with	ed training include: of Alzheimer's disease and activities of daily living; with challenging behaviors;				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			E SURVEY PLETED
		00655	B. WING		07/26/2018	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY,	STATE, ZIP CODE		
	ON MUNICIPAL HOSI	ρίτδι	TH BEHL STR ON, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENC	AFFLE I ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 302	written or electronic training program, the trained, the frequent topics covered. (d) The facility shall this section. This MN Requirem by: Based on interview facility failed to pro- on resident Alzhein training including d 5 employees (E2, F dementia care train Findings include: The Appleton Area assessment dated following: Services and Care Residents' needs-N behavior-Manage t medication-related symptoms and beh interventions to hel issues such as dea someone with cogri	skills. I provide to consumers in c form a description of the he categories of employees ney of training, and the basic Il document compliance with ent is not met as evidenced and document review, the vide the required initial training ner's disease and related ementia management for 5 of E3, E4, E5, E6) reviewed for hing. Health Services facility 11/24/18, included the e we offer Based on our		Corrected		
	disabilities.	tual or developmental llowing employee education wed:				
nnesota D ATE FORI	epartment of Health M		6899	HB6111	If continua	tion sheet 8 c

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	00655		B. WING		07/	26/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSE		HBEHL STRE N, MN 56208			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 302	<ul> <li>E2, hired as a die</li> <li>E3, hired as a nur</li> <li>E4, hired as a nurs</li> <li>E5, hired as a nurs</li> <li>All five employee redementia training h</li> <li>On 7/25/18, at 10:0 (DON) identified the not received trainin</li> <li>Alzheimer or deme the all staff yearly e completed next were receive the training indicated new staff without training for identified the facility completing the Alzr before working directly with stated, "going forware completed."</li> <li>SUGGESTED MET The administrator or review, and /or review,</li></ul>	<ul> <li>A provide the second develop, se policies and procedures to the galaxies.</li> </ul>	2 302			

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:			LE CONSTRUCTION ()	(3) DATE SURVEY COMPLETED	
	00655		B. WING		07/26/2018
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
PPLET	ON MUNICIPAL HOSI		H BEHL STR DN, MN 5620		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE
2 302	Continued From pa	age 9	2 302		
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one			
2 920	MN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	2 920		8/22/18
	comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,			
	by: Based on observat review, the facility f oral hygiene assist	ent is not met as evidenced ion, interview, and document ailed to provide grooming and ance for 1 of 3 residents (R25) tance from staff to complete ing.		Corrected	
	Findings include:				
	8/30/17, identified I included dementia, impaired vision. Th had severe cognitiv	num Data Set (MDS) dated R25 had diagnoses which arthritis, depression, and e MDS further identified R25 ve impairment,was not able to extensive staff assistance with ing.			
	had dementia, upp teeth, and required with personal hygie plan identified R25	vised 9/13/17, identified R25 er dentures and his own lower extensive staff assistance ene and oral cares. The care required oral inspection QD al cares and PRN (as needed),			

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If continuation sheet 10 of 30

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00655	B. WING			
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		07/26/	
		30 SOUT	TH BEHL STRE			
AFFLEI	ON MUNICIPAL HOS	APPLET	ON, MN 56208			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	age 10	2 920			
	stated facility staff assistance to shav teeth. FM-A stated home, and liked to indicated R25's bre and staff were aler	7 p.m. family member (FM)-A did not provide R25 daily re his face and brush his lower R25 had shaved daily at be clean shaven. FM-A further eath had been foul in the past ted to brush his teeth, s continued to not be				
	was present in R25 with morning cares denture from the b water and placed t then began to orga linens, and garbag present on his face	D a.m. nursing assistant (NA)-C 5's room providing assistance s. NA-C obtained R25's upper athroom, rinsed them with hem in R25's mouth. NA-C anize the room, gather the e. R25 had facial stubble/hair e. NA-C did not offer to shave care offered for R25's lower				
	morning cares wer indicated shaving f needed. NA-C stat because she felt h on his face to requi indicated R25's de and mouth rinsed v R25's teeth were n R25's bathroom ar conducted with NA denture products a	6 a.m. NA-C verified R25's re provided as usual. NA-C for R25 was provided as ed she had not shaved R25 e did not have enough stubble ire shaving assistance. NA-C ntures were brushed at night with a mouth wash, however; not brushed. Observation of nd above the sink cabinet was A-C, NA-C was able to locate and mouthwash. R25's did not include a tooth brush				
	(DON) indicated FI R25's care and wo	06 a.m. the director of nursing M-A was very involved with uld know his choices. The e felt the facility honored				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	00655		B. WING		07/26/2018	
IAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
PPLET	ON MUNICIPAL HOSI	ρίτδι	JTH BEHL STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	age 11	2 920			
	resident was shave expected staff prov	choice of how often a male ed. The DON confirmed she vide assistance to shave and eth for those who require				
	7/2018, The purpose clean and freshen prevent infections of teeth and gums in	tled Teeth Brushing, revised ses of the procedure are to the resident's mouth, to of the mouth, to maintain the a healthy condition, to s, and to remove food particle eeth.	s			
	The director of nur employees respons for residents the ne	THOD OF CORRECTION: sing could in-service all sible for providing direct cares eed to follow the residents re plan. Also to monitor for	S			
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-on	e			
21385	MN Rule 4658.080 Staff assistance	0 Subp. 3 Infection Control;	21385			8/22/18
	Personnel must be infection control pro the residents and r	istance with infection control. assigned to assist with the ogram, based on the needs o hursing home, to implement ocedures of the infection				
	by:	ent is not met as evidenced				
	Based on observat	ion, interview, and document		Corrected		

STATE FORM

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If continuation sheet 12 of 30

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
00		00655	B. WING	B. WING		26/2018
IAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE	•	
סט בד		30 SOU	TH BEHL STRE	ET		
APPLEI	ON MUNICIPAL HOSI	APPLE	FON, MN 56208	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21385	Continued From pa	lge 12	21385			
	infection control me to the care of cathe	ailed to ensure appropriate easures were followed related eter drainage bags for 2 of 2 ) observed with an indwelling				
	Findings include:					
	dated 4/3/18, indica and had diagnoses prostatic hyperplas and retention of uri R3 required extens bed mobility, transf	ange Minimum Data Set (MDS ated R3 was cognitively intact which included benign ia (BPH), obstructive uropathy ne. The MDS also indicated ive assistance of one staff for ers, dressing, toilet use, and R3's MDS further indicated the ig catheter.	/,			
	was at risk for infect community living se integrity, Diabetes I incontinent of blade revealed a history of and the use of an in BPH, urinary retent care plan directed se twice daily, use cat of trauma, position	revised 7/17/18, indicated R3 stion related to age, chair fast, etting, compromised skin Mellitus, and occasionally der. R3's care plan further of urinary tract infections (UTI) ndwelling catheter related to ion, and prostate cancer. The staff to complete catheter care heter secure to decrease risk catheter bag below level of catheter collection bag with Il times for dignity.	), 9			
	back with his eyes lowest position, aga mat was on the floo tube was observed footboard and the v followed to the floo	a.m. R3 lay in bed on his closed. His bed was in the ainst a wall, and a maroon fall or next to the bed. A catheter between the end of the R3's vall. The catheter tubing was r where a catheter drainage lying flat on the floor with the				

STATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00655	B. WING		07/	26/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		30 5011	H BEHL STRE			
APPLET	ON MUNICIPAL HOSI	PITAL APPLET	ON, MN 56208	3		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T		COMPLET DATE
IAG			IAG	DEFICIENC		
21385	Continued From pa	age 13	21385			
2.000		-	21000			
	side of the bag with the opening spout resting on					
	the floor. No cover	was observed on the bag.				
	At 0.36 a m. nursin	g assistant (NA)-A entered				
		t him with morning cares. NA-A				
		and donned gloves, raised	`			
		n washing R3's perineal area				
		. R3's catheter drainage bag				
		on the floor with the side with				
	the opening spout	resting directly on the floor. At				
		ted R3 had a problem				
		er and used a catheter. She				
		room, obtained a plastic				
		, a paper towel, and an alcohol				
		to R3's bed. NA-A placed the				
		y on the floor near R3's				
		ed the plastic cylinder onto the				
		then reached over R3's legs				
	0	atheter tubing near the				
		ed the catheter drainage bag NA-A pulled up on the tubing,				
		ie with white fibrous sediment				
		catheter tubing towards R3's				
		red the catheter drainage bag				
		the floor on it's face and				
		drainage bag was usually				
		pasin on the floor. No plastic				
		R3's room. NA-A then bent				
	down next to the cy	linder on the paper towel and				
		ge bag spout and emptied the				
		illing two small areas				
		e inches in diameter of urine				
		A wiped the drainage bag spou	t			
		e, closed the spout and hung				
		ge bag on to the footboard				
		plastic hook. NA-A then				
		nto the toilet, rinsed the				
		ed a cloth hand towel, soaked				
		rned to the end of R3's bed. e spilled areas of urine and				
		spined areas of utilite and				

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00655	B. WING		07/	26/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
APPLET	ON MUNICIPAL HOS	ριται	H BEHL STRE ON, MN 56208			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21385	Continued From pa	age 14	21385			
	placed the towel in	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.				
	with NA-B to assist power wheelchair. drainage bag off of to the mechanical s transferring the dra urine fell from the of floor. NA-A and NA power wheelchair. off of the mechanic onto R3's power w NA-A if R3 had a d conceal a urine dra dignity purposes an infection control pu one a long time ag while. NA-A and NA dignity bag, but one room pushing out t R3's room leaving directly on R3's por between his shoes observed to clean R3's floor. At 10:22 room with a black of attached it to the b	A left R3's room and returned ther with transferring R3 to his NA-B grabbed R3's catheter if the footboard and attached it stand for the transfer. While ainage bag multiple drops of drainage spout directly onto the A-B then transferred R3 to his NA-A took R3's drainage bag cal lift and placed it directly heelchair footrest. NA-B asked ignity bag (a bag used to ainage bag used for resident and also acts as a barrier for irposes). NA-A stated R3 had o and has not seen it in a A-B looked in R3's room for a e was not found. NA-B left R3's the mechanical stand. NA-A left the catheter drainage bag lying wer wheelchair footrest . Neither NA-A or NA-B were the multiple drops of urine on 2 a.m. NA-A returned to R3's colored dignity bag and ase of R3's power wheelchair. ie drainage bag inside of the	5 t			
	assisting him with drainage bag laid of foot end of the bed bag on the floor, pi	5 a.m. NA-A was in R3's room morning cares. R3's catheter directly on the floor near the I. NA-A looked at the drainage cked it up, and placed it on the e attached plastic hook. NA-A				

STATE FORM

HB6111

If continuation sheet 15 of 30

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00655	B. WING		07/26/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	TATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSI	ρίτδι	TH BEHL STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21385	Continued From pa	age 15	21385			
	prior and was move bed. A plastic basir	e bag was on the footboard ed due to R3 moving around in a for holding the drainage bag on the floor or in R3's room.				
	(TMA)-A stated cat never be directly or control concerns. T should be hooked t in place, but R3's b when occupied, so	a.m. trained medication aid heter drainage bags should in the floor due to infection MA-A indicated drainage bags to the bed frame to keep them bed was kept in the low positio staff would use a plastic basin ge bag in to keep it off of the	n			
	(RN)-A stated cathe never touch the flor concerns. RN-A ind bag should be hung his bed was lowere touch the floor. RN practice was to use	A1 a.m. registered nurse eter drainage bags should or due to infection control dicated R3's catheter drainage g by the bed frame, but when ed the drainage bag would -A stated that staff's normal e pillow cases to create a e catheter drainage bag and				
	(DON) stated R3 h risk for infection, an DON stated catheted directly on the floor	7 p.m. director of nursing ad a history of UTIs and was a nd developing another UTI. er drainage bags should not b due to infection control issue of the catheter drainage bag.	e			
	R30 was cognitivel which included neurogenic bladder	OS dated 6/12/18, indicated y intact and had diagnoses r, bladder disorder and S also indicated R30 required				

Minnesota Department of Health STATE FORM

6899

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		00655	B. WING		07/	07/26/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
APPLET	ON MUNICIPAL HOSF	ρίται	H BEHL STREE DN, MN 56208	ET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21385	toilet use, personal assistance of one for MDS also indicated indwelling catheter. R30's care plan rev was at risk for infect disease (renal disea community living se indwelling/intermitte plan indicated R30 related to flaccid bla staff to provide cath catheter bag and tu bladder, away from likes catheter tubing During observations was in her room se catheter tubing ran the way to the floor bag was observed I with the opening sp and was not covere drainage bag had b indicated she did no covered and lying o company in her roo could cover it with se During observation R30's was seating i R30's catheter tubing leg all the way to the drainage bag was o tile flooring with the on the floor and wa	hygiene and limited by bed mobility and transfers. R30 required the use of an ised on 6/27/18, indicated R30 tion related to age, chronic ases, congestive heart failure), etting, diabetes mellitus, ent catheterization. R30's care had an indwelling catheter adder. The care plan directed heter care twice daily, position bing below the level of the entrance of door and when up g going down left leg. s on 7/23/18 at 2:13 p.m. R30 ated in a brown recliner, R30's directly down her left leg all where the catheter drainage ying directly on the tile flooring out resting directly on the floor rd. R30's catheter tubing and right yellow urine noted. R30 ot like her catheter bag not n the floor when she had m and stated "I wish they					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00655	B. WING		07/26/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
APPLET	ON MUNICIPAL HOS	ριται	H BEHL STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21385	was seated in her r R30's catheter tubi leg all the way to the drainage bag was of tile flooring, spout of R30's catheter tubi bright yellow urine -at 1:52 RN-A ente R30's catheter drait tile flooring face do R30's catheter tubi bright yellow urine catheter bag lying of hung it on the side confirmed the above needed assistance cares and activities indicated R30's catheter be lying directly on something around RN-A stated this we and dignity. RN-A in residents are in the	is on 7/26/18 at 1:50 p.m. R30 recliner in her room sleeping. ng ran directly down her left ne floor where the catheter observed lying directly on the down and was not covered. ng and drainage bag had				
	in her room, staff w drainage bag rest o not cover it. R30 in when she has had	a.m. R30 verified when she's vill just let her catheter on the floor full sometimes and dicated it was embarrassing company in her room and its oor or hang her catheter bag n.	ł			
	needed staff assist use of indwelling ca assistance with cat	p.m. DON confirmed R30 ance with ADL's, utilized the atheter and needed theter cares. DON verified bags need to be covered if				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00655	B. WING	B. WING		26/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
APPLET	ON MUNICIPAL HOS	διται	TH BEHL STRE ON, MN 56208			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21385	going on a surface The DON also com the catheter bags f case she has visito expectations of sta the catheter draina need to do a better Review of facility p Urinary revised on of this procedure is associated urinary control: use standa or manipulating the clean technique wh the catheter, tubing	age 18 due to infection control issues firmed staff should be covering or dignity issues as well in ors. The DON indicated his ff would be to have them cove ge bags and indicated staff job with this on skills day. olicy titled, Catheter Care 7/2018, indicated the purpose is to prevent catheter tract infections. under infection and precautions when handling e drainage system, maintain nen handling or manipulating g, or drainage bag and be sure and drainage bag are kept off	r n			
	The Director of Nur review or revise po proper infection co in-service in regarc procedures, and co policies and proced	THOD FOR CORRECTION: rsing or designee(s) may licies and procedures requiring ntrol methods , provide an to these policies and onduct audits to ensure the dures are being implemented. R CORRECTION: Thirty (30)	3			
	Subp. 7. Hot wate supplied to sinks a maintained within a	5 Subp. 7 Plant eration, & Maintenance r temperature. Hot water nd bathing fixtures must be a temperature range of 105 it to115 degrees Fahrenheit at	21710			8/22/18

6899

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED	
		00655	B. WING	B. WING		07/26/2018	
NAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
APPLET	ON MUNICIPAL HOS		TH BEHL STR ON, MN 562				
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE	
21710	Continued From pa	age 19	21710				
	by: Based on observat review, the facility t environment that w related to resident temperatures in 2 d	vas free of accident hazards, bathroom hot water of 3 resident halls. This had the Ill 32 residents who currently	e	Corrected			
	Finding include:						
	maintenance (DM) of the building. Wa room sinks and ba South hallway were	4 p.m. room water e reviewed with the director of -A in all three resident hallway ter temperatures in resident throom sinks in the North and e found to be hot to touch in 19, 214, 217, 247, 240, 250.	S				
	felt too warm, indic be between 114 and however; temperate out the day. The D South hallways rec basement which have water that is 140 de water to reach the The DM-A identifie the hospital. The D water temperatures designated mainte identified the water South halls, located reading of 118 deg temperatures could	D p.m. DM-A verified the water rated the temperatures were to ad 117 degrees Fahrenheit (F), ures did very slightly through M-A indicated the North and reived water from the ad a mixing valve where the egrees F is mixed with cool 114 to 117 degree F range. d the west wing is regulated by DM-A indicated resident room s were to be checked daily by nance staff person. DM-A r system for the North and d in the basement had a ree F, however, true water d not be measured due to the misplaced. The DM-A	/				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			E SURVEY PLETED	
		00655	B. WING		07/	06/0019	
	PROVIDER OR SUPPLIER		B. WING 07/26/2018 ADDRESS, CITY, STATE, ZIP CODE				
	ON MUNICIPAL HOS	30 SOUT	H BEHL STRE				
	DN MONICIPAL NOS	APPLET(	ON, MN 56208	3			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21710	Continued From pa	age 20	21710				
	temperature for the approximately two	e North and South halls degrees F.					
	temperatures at ea and South halls we thermometer by the thermometer. The were measured in bathroom sinks: South hall room 20 -room 204 was 119 -room 213 was 119 -room 214 was 120 -room 218 was 119 -room 222 was 120 North wing room 22	<ul> <li>) degrees F</li> <li>) degrees F</li> <li>) degrees F</li> <li>) degrees F</li> <li>30 through room 251</li> <li>ared bathroom was 119</li> <li>3 degrees F</li> </ul>					
	circulation made a on the South hall w of 119 or 120 degre North hall would be degrees F. The DN temperature was to water continued to turn the water temp	documentation of the daily					
		olicy titled, Safe Water					
inesota De	epartment of Health		r				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COM	PLETED
		00655	B. WING		07/	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSE	ρίτδι	H BEHL STRE DN, MN 56208			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21710	Continued From pa	ige 21	21710			
	directed: Hot water competent mainten basis to insure that between the tempe Fahrenheit and 117 outside of this rang	cation, reviewed 1/1/18, r will be monitored by a ance technician on a daily our hot water temperature is wratures of 113 degrees degrees Fahrenheit. Anything e is unacceptable and must be ntly as possible to correct the				
	The Environmental and/or designee co system to log the d educate staff on the weekly basis to ens	THOD FOR CORRECTION: Director, Director of Nursing uld monitor and develop a aily temperature checks, e policies and audit on a sure water temperatures are 15 degrees Fahrenheit.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21840	MN St. Statute 144 Residents of HC Fa	.651 Subd. 12 Patients & ac.Bill of Rights	21840			8/22/18
	residents shall have based on the inform 9. Residents who r or dietary restriction likely medical or ma the refusal, with do medical record. In of incapable of unders has not been adjud legal requirements treatment, the cond	o refuse care. Competent e the right to refuse treatment nation required in subdivision refuse treatment, medication, ns shall be informed of the ajor psychological results of cumentation in the individual cases where a resident is standing the circumstances but licated incompetent, or when limit the right to refuse ditions and circumstances shall d by the attending physician in cal record.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00655	B. WING		07/26/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	•	
APPLET	ON MUNICIPAL HOSI	ριται	H BEHL STF ON, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE	(X5) COMPLET DATE
21840	Continued From pa	age 22	21840			
	by: Based on interview facility failed to ens resuscitation status	ent is not met as evidenced and document review, the ure resident current wishes for were accurately documented d for 1 of 2 residents (R35) ced directives.		Corrected		
	Findings include:					
	12/27/17, indicated diagnoses which in	inimum Data Set (MDS) dated R35 had intact cognition, and cluded dementia, atrial obstructive pulmonary disease onary embolism.				
	dated 12/5/06, india for R35. However, Condition Instruction R35 had a terminal express her wishes condition, R35 wish	ealth Care Directive (HCD) cated no certain code status R35's HCD had Terminal ons, that were to be used only i condition and was unable to s. In the event of a terminal ned to be allowed to die e kept alive by artificial means S.	f			
	Transfer Form date	hysician signed Care Center ed 12/21/17, indicated R35 o Not Resuscitate (DNR)				
		rder Summary Report signed rder for R35's code status.				
	indicated on page of	are plan revised on 7/17/18, one, under the header Special Code [to resuscitate] 12/21/17".				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00655	B. WING		- 07/26/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
APPLET	ON MUNICIPAL HOS	διται	TH BEHL STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21840	Continued From pa	age 23	21840			
		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.					
	stated a resident's determined by che chart for a red hea the heart sticker, th the inside cover of RN-A reviewed the confirmed R35's ch then opened R35's inside cover indica RN-A reviewed R3 vague and only sta	D a.m. registered nurse (RN)-A code status would be cking the spine of the hard rt sticker. If the chart lacked nen there would be a sticker or the chart indicating DNR. e spine of R35's hard chart and nart lacked the sticker. She s chart and the sticker on the ted "Advanced Directive." 5's HCD and indicated it was the R35's wishes if she was firmed R35 was not terminal above findings.	1			
	(DON) stated any r with a HCD, would designee (SSD) ar status. DON review	5 a.m. director of nursing resident admitted to the facility meet with the social services nd review their wishes for code ved R35's electronic health chart and confirmed the above				
	DON, he stated the would be the perso sticker on the spine had wished to have	ng a follow up interview with the e SSD, or her replacement, on to place the red, heart e of the chart, if the resident e cardiopulmonary t). The DON indicated that	•			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00655	B. WING	B. WING		07/26/2018	
NAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
APPLET	ON MUNICIPAL HOSI	ριται	TH BEHL STRE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21840	Continued From pa	age 24	21840				
	choose CPR, and t indicator that staff	filled out by residents that he heart sticker was the would look for to represent the The DON stated, "This one					
	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.		e t				
	Directives approve advance directive of obtained and locate the resident's medi readily retrievable b Resident wishes w via the care plan and communication of a	ty policy titled Advanced d 7/18, indicated "D. All document copies will be ed (identify the same section o ical record that would be by any facility staff)." "E. ill be communicated to the stat nd (identify facility protocol for advance directives either in at) and to the resident					
	The administrator, designee could rev advanced directive staff. The quality a	THOD OF CORRECTION: director of nursing (DON), or iew the facility policy related to as and provide education to all assurance designee could r ongoing compliance.					
	TIME PERIOD FO (21) day	R CORRECTION: Twenty-one	•				

	ta Department of He					
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00655	B. WING		07/26/201	8
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSP	ρίται	H BEHL STRE DN, MN 5620			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COM	X5) IPLETE ATE
21880	Continued From pa	ge 25	21880			
21880	MN St. Statute 144 Residents of HC Fa	.651 Subd. 20 Patients & ac.Bill of Rights	21880		8/22/	/18
	their stay in a facility to understand and a patients, residents, residents may voice changes in policies and others of their of interference, coerci including threat of of grievance procedur well as addresses a Office of Health Fa nursing home ombut Americans Act, sec posted in a conspic Every acute care residential program	inpatient facility, every as defined in section				
	facility employing m provides outpatient have a written inter at a minimum, sets followed; specifies t limits for facility res or resident to have advocate; requires	acute care facility, and every fore than two people that mental health services shall rnal grievance procedure that, forth the process to be time limits, including time ponse; provides for the patient the assistance of an a written response to written povides for a timely decision by				
	an impartial decisio otherwise resolved. residential program 253C.01 which are treatment programs centers with section	n maker if the grievance is not Compliance by hospitals, ns as defined in section hospital-based primary s, and outpatient surgery 144.691 and compliance by e organizations with section				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00655	B. WING		07/2	26/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSE	σιται	H BEHL STR DN, MN 5620			
(X4) ID	SUMMABY STA			PROVIDER'S PLAN OF C	OBBECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLET
21880	Continued From pa	ige 26	21880			
		to be compliance with the rritten internal grievance				
	by: Based on observati review, the facility f	ent is not met as evidenced ion, interview, and document ailed to provide services in a ir 1 of 2 residents (R30) who neter.		Corrected		
	Finding include:					
	6/12/18, indicated F had diagnoses which bladder, bladder dis MDS also indicated assistance of one s personal hygiene, a for bed mobility and	imum Data Set (MDS) dated R30 was cognitively intact, and ch included neurogenic sorder, and diabetes. The I R30 required extensive staff for dressing, toilet use, and limited assistance of one d transfers. MDS also indicated se of an indwelling catheter.				
	R30 was at risk for chronic disease (re failure), community mellitus, and indwe catheterization. Fur indicated R30 had to flaccid bladder. T provide catheter ca catheter bag and tu bladder, away from	rised on 6/27/18, indicated infection related to age, nal diseases, congestive heart living setting, diabetes illing/intermittent ther review of R30's care plan an indwelling catheter related The care plan directed staff to the care plan directed staff to the entrance of the door, and the catheter tubing going				

Minnesota Department of Health           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           AND PLAN OF CORRECTION         IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00055					
		00655	B. WING		07/26	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
APPLET	ON MUNICIPAL HOS	ριται	'H BEHL STRE ON, MN 56208			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21880	Continued From pa	age 27	21880			
	During observation was in her room set catheter tubing ran the way to the floor bag was observed face down and was tubing and drainag noted. R30 indicate bag uncovered and had company in her could cover it with During observation was seated in her r catheter tubing ran the way to the floor bag was observed face down and was tubing and drainag it. -at 2:10 p.m. R30 w her room with her f recliner sleeping. F directly down her le catheter drainage bag floor directly out in was uncovered. R3 drainage bag had b During observation was lying in bed wi slightly, and was w catheter tubing ran her bed all the way bag which was obse basin, which was s on the side of R30'	Is on 7/23/18, at 2:13 p.m. R30 eated in a brown recliner. R30's directly down her left leg all r, where the catheter drainage lying directly on the tile flooring is uncovered. R30's catheter e bag had bright yellow urine ed she did not like her catheter d lying on the floor when she er room and stated, "I wish they something." I on 7/24/18, at 10:40 a.m. R30 recliner in her room. R30's directly down her left leg all r, where the catheter drainage lying directly on the tile flooring is uncovered. R30's catheter e bag had bright yellow urine in was seated in her recliner in feet up on the foot rest of her R30's catheter tubing ran eft leg all the way down to the bag which was observed lying asin, which was setting on the front of R30's recliner, and 80's catheter tubing and bright yellow urine in it. Is on 7/25/18, at 7:29 a.m. R30 th head of bed elevated orking on her computer. R30's directly down the right side of r down to the catheter drainage served lying directly in a gray etting on the floor directly out s bed and was uncovered. ng and drainage bag had				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED	
	00655		B. WING		07/	26/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
APPLET	ON MUNICIPAL HOSI	ριται	H BEHL STRE ON, MN 56208			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
21880	Continued From pa	age 28	21880			
	was seated in her r R30's catheter tubi leg all the way to the drainage bag was of tile flooring face do catheter tubing and yellow urine in it. -at 1:52 registered room and observed lying directly on the uncovered. R30's of bag had bright yello for R30's catheter he on the side of R30's finding and verified staff with all catheter living (ADLs). RN-A drainage bag shoul floor, and should ha protect it like a barn infection control iss indicated normally rooms, staff will use catheter drainage he On 7/25/18, at 9:38 in her room, staff w drainage bag lay on not cover it. R30 in when she has had the bag is just layin garbage can. On 7/26/18, at 9:35 (TMA)-A confirmed	8 a.m. R30 verified when she's ill just let her catheter in the floor full sometimes, and dicated it was embarrassing company in her room, when ig on the floor or hung on the 5 a.m. trained medication aid catheter drainage bags tly on the floor, but should be	3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
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		00655	B. WING		07/	26/2018	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
PPLET	ON MUNICIPAL HOS	ριται	TH BEHL STRE ON, MN 56208				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21880	Continued From pa	age 29	21880				
	On 7/26/18, at 4:23 (DON) confirmed F with ADLs, utilized catheter, and need cares. DON verified to be covered if go floor) due to infecti also confirmed stat catheter bags for d visitors. The DON staff would be to ha drainage bags. Review of facility p Dignity revised on shall be cared for in enhances quality o individuality. SUGGESTED MET Director of Nursing and revise policies educate staff on th audits to ensure ea honored.	B p.m. the director of nursing 30 needed staff assistance the use of an indwelling ed assistance with catheter d catheter drainage bags need ing on a surface (such as the on control issues. The DON ff should be covering the lignity issues in case she has indicated his expectations of ave them cover the catheter olicy titled Quality of Life 7/2018, indicated each residen n a manner that promotes and f life, dignity, respect, and THOD OF CORRECTION: The and/or designee could review pertaining to resident rights, ese policies and perform ach resident's rights have been R CORRECTION: Twenty One	it e				
	(21) days.	IT CONTLECTION. Twenty One					