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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

ID: O9ET

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

Facility ID: 00655

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245231**
2.STATE VENDOR OR MEDICAID NO.
(L2) **705040200**

3. NAME AND ADDRESS OF FACILITY
(L3) **APPLETON AREA HEALTH**
(L4) **30 S BEHL ST**
(L5) **APPLETON, MN** (L6) **56208**

4. TYPE OF ACTION: **7** (L8)
**1. Initial** **2. Recertification**
**3. Termination** **4. CHOW**
**5. Validation** **6. Complaint**
**7. On-Site Visit** **9. Other**
**8. Full Survey After Complaint**

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/12/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

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

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathleen Lucas, District Supervisor 09/02/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 09/02/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**00131**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
September 2, 2021

CMS Certification Number (CCN): 245231

Administrator
Appleton Area Health
30 S Behl St
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 August 9, 2021 the above facility is certified 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
September 2, 2021

Administrator
Appleton Area Health
30 S Behl St
Appleton, MN 56208

RE: CCN: 245231
Cycle Start Date: June 30, 2021

Dear Administrator:

On July 16, 2021, we notified you a remedy was imposed. On August 12, 2021 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 9, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 31, 2021 be discontinued as of August 9, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of July 16, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 30, 2021. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered

September 2, 2021

Administrator
Appleton Area Health
30 S Behl St
Appleton, MN 56208

Re: Reinspection Results
Event ID: O9ET12

Dear Administrator:

On August 12, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 12, 2021. At this time these correction orders were found corrected.

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

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

ID: O9ET

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

Facility ID: 00655

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245231**
2.STATE VENDOR OR MEDICAID NO.
(L2) **705040200**

3. NAME AND ADDRESS OF FACILITY
(L3) **APPLETON AREA HEALTH**
(L4) **30 S BEHL ST**
(L5) **APPLETON, MN** (L6) **56208**

4. TYPE OF ACTION: **2** (L8)
**1. Initial** **2. Recertification**
**3. Termination** **4. CHOW**
**5. Validation** **6. Complaint**
**7. On-Site Visit** **9. Other**
**8. Full Survey After Complaint**

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/30/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
**X** B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Nicole Sassen, HFE - NE II 08/24/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 09/01/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**00131**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically Submitted
July 16, 2021

Administrator
Appleton Area Health
30 S Behl St
Appleton, MN 56208

RE: CCN: 245231
Cycle Start Date: June 30, 2021

**Please Note: The health and life safety code survey findings will be processed under separate enforcement cycles.**

Dear Administrator:

On June 30, 2021, survey was completed at your facility by the Minnesota Department of Health 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

## REMOVAL OF IMMEDIATE JEOPARDY

On June 30, 2021, the situation of immediate jeopardy to potential health and safety cited at F689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

## REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 31, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see

electronically attached documents for the DPOC.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 31, 2021, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 31, 2021, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

## NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 30, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

## SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard

quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Appleton Area Health is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 30, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

## ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

## DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded

by an "E" tag), i.e., the plan of correction should be directed to:

Kathleen Lucas, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Office: (320) 223-7343 Mobile: (320) 290-1155

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 their respective deficiencies (if any) is acceptable.

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

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 December 30, 2021 (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.

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.

## APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

## APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

## INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112  Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>On 6/28/21 to 6/30/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance.<br><br>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>On 6/28/21-6/30/21, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance.<br><br>The survey resulted in an Immediate Jeopardy (IJ) at F689 when R23 was observed smoking a cigarette in the designated smoking area while using a portable oxygen concentrator via nasal cannula and the oxygen was observed to be turned on. Smoking cigarettes in conjunction with using oxygen can rapidly accelerate combustion. This could result in significant injury or death to the residents, staff, and visitors in the area. The Administrator and Director of Nursing (DON) were notified of the immediate jeopardy at 1:36 p.m. on 6/29/21. The immediate jeopardy was removed on 6/30/21, at 1:38 p.m. but non-compliance remained at an isolated scope and severity which indicated no actual harm with potential for more than minimal harm (Level D). | F 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 07/23/2021 |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | Continued From page 1<br><br>The above findings constituted substandard quality of care, and an extended survey was conducted from 6/29/21 to 6/30/21.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility | F 550 | | 8/4/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 550 | Continued From page 2<br>must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review the facility failed to ensure 3 of 4 residents (R4, R18, and R40) were provided a dignified dining experience.<br><br>Findings include:<br><br>R4's quarterly minimum data set (MDS) dated 3/24/21, indicated moderate cognitive impairment and was independent with eating.<br><br>R18's quarterly MDS dated 6/2/21, indicated severe cognitive impairment and needed assistance with eating.<br><br>R40's significant change MDS dated 4/19/21, | F 550 | 1.It is the policy of this facility to treat each resident with respect, dignity and to provide a dignified dining experience. One of several ways this is accomplished is serving our resident using a steam tables offering real-time choices for warm food items. In addition, our dietary and nursing staff work together to provide a pleasant dining experience. In this case, after the surveyor reported residents receiving meals at different times while seated at the same table, nursing staff was reminded to serve one table at a time before moving to the next table.<br>2.All residents receiving meals at this facility are potentially affected by the cited | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 550 | Continued From page 3<br>indicated severe cognitive impairment and required supervision with eating.<br><br>During observation on 6/28/21, at 11:57 a.m. unknown dietary aid brought R4 her meal. R40 and R18 were already sitting at table with R4. Other residents in dining room being asked what they want for meals. No one asked R40 or R18 what they wanted to eat.<br><br>During observation on 06/28/21, at 12:05 p.m. R40 reached across table and took a bite of R4's food. R4 stated "that is mine". Other individuals were in the dining room receiving there meals from staff.<br><br>During observation on 6/28/21, at 12:07 R40 received her meal.<br><br>During observation on 6/28/21, at 12:11 p.m. 18 received her meal tray. Staff assisting with cutting up food at table at table 1.<br><br>During interview on 6/29/21, at 12:44 p.m. dietary aide (DA)-A stated when passing out trays all individuals at that same table should be delivered their meals at the same time. DA-A stated it is not fair nor acceptable for residents to watch others at the same table eating.<br><br>During interview on 6/29/21, at 12:55 p.m. train medication aide (TMA)-A stated when staff are passing meal trays in the dining room they should be serving everyone at one table first before moving to the next one. TMA-A further stated it was not ok for one resident to get food and the other ones to wait and watch that individual eat.<br><br>During interview on 6/29/21, at 1:30 p.m. licensed | F 550 | deficiency.<br>3.To enhance the Care Center operations and under the direction of the Director of Nursing or designee, dietary and nursing staff will receive in-service training on state and federal requirements on providing a dignified dining experience. The training will emphasize residents seated together should be served before serving the next table. The policy for assisting residents with meals has been updated with dining room procedure which includes serving resident meals. The dining room procedure also includes a License Nurse to be present in the dining room during meals.<br>4.Director of Nursing or designee will perform daily audits four days per week x3, then weekly x3, then monthly x2. Results of the audits will be reported to the QA committee for review and action, as appropriate. The QA committee will determine the need for further audits and/or action plan. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 550 | Continued From page 4<br>practical nurse (LPN)-B stated staff grab a name tag and then find the resident in the dining room and ask them what they would like to eat. LPN-B further stated there is no rhyme or reason to who the staff grab first. LPN-B stated they should be serving everyone at the table before moving on to the next. LPN-B further stated it is not right to have one person served first and then the others having to wait. LPN-B stated if that was me "I would be upset".<br><br>During interview on 6/29/21, at 4:59 p.m. registered nurse (RN)-A stated the dining process has now changed to residents eating in the dining room. RN-A stated they need to work on some of the processes in the dining room. RN-A further indicated it is a dignity issue when you have one resident served their meal and the others at the table just waiting.<br><br>During interview on 6/30/21, at 10:35 a.m. the director of nursing (DON) stated all residents should be served one table at a time and it is not ok otherwise. DON further stated "I wouldn't want someone eating in my face while I am waiting".<br><br>Requested policy for dining room procedure: no policy regarding this. Facility did supply policy for assistance with meals expired 6/21. | F 550 | | |
| F 554 SS=D | Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)<br><br>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.<br>This REQUIREMENT is not met as evidenced by: | F 554 | | 8/4/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 554 | Continued From page 5<br>Based on observation, interview and record review, the facility failed to assess self-administration of medication for 1 of 1 residents (R5) reviewed for self-administration of medication.<br><br>Findings include:<br><br>R5's MDS dated 3/24/21, indicated R5 had moderate cognitive impairment and was usually able to understand others. R5's diagnosis included Parkinson's, schizoaffective disorder and bipolar.<br><br>During observation of medication pass on 6/29/21, trained medication aid (TMA)-A stated R5 prefers his medications in applesauce. After setting up his medications, TMA-A left them in his room and stated R5 will take them when he is ready. TMA-A proceeded to set up three oral medications in a plastic medication up. TMA-A then put applesauce into a separate medication cup. TMA-A brought both medications cups to R5's room, placed them on the table next to his chair and told him they were there. R5 acknowledged TMA-A but did not make attempts to reach for either of the medication cups prior to TMA-A leaving the room. TMA-A explained she will return to his room approximately one hour after leaving the medications to check if he took them. TMA-A stated, usually after the checking on him after approximately three times, he will then take his medications, "He knows what he is doing." TMA-A was not aware if R5 had been assessed by a nurse to determine if he was safe to self-administer his medications.<br><br>On 6/30/21, at 8:52 a.m. RN-A stated residents are not able to self-administer medications | F 554 | 1.It is the policy of this facility to administer medication according state and federal regulations and nursing standards of practice. One of several ways this is accomplished is resident identification using a photo in the EHR prior to administering medication. Additionally, the TMA is delegated by the nurse, the task of medication administration in a safe manner. In this case, after the surveyor reported medication was left unattended for R5 to self-administer; R5 was not negatively impacted by the cited deficiency. TMAs were reminded that medication should not be left with any resident that has no provider order for self-administration and a self administration assessment.<br>2.All residents that do not have a self-administration assessment and no provider order are potentially affected by the cited deficiency.<br>3.To enhance the Care Center medication administration practices, the Director of Nursing or designee will in-service license nurses and TMA□s on the facility policy, Self-Administration of Medication.<br>4.Director of Nursing or designee will audit daily medication administration of TMA□s weekly x3, then monthly x2. Results of the audits will be reported to the QA committee for review and action, as appropriate. The QA committee will determine the need for further audits and/or action plan. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 554 | Continued From page 6<br>without being assessed and found safe to do so. The TMA would know a resident can self-administer medications because there would be a message on the top banner, for that resident, on the medication page in the computer. RN-A confirmed R5 was not assessed to self-administer his medications and medications should not be left with R5. RN-A expected the TMA to remain with R5 until he successfully took his medications.<br><br>on 6/30/21, at 1:53 p.m. director of nursing (DON) stated before a resident is able to self-administer medications, she expected there to be a self-administration assessment in the resident's chart and an order from the provider. DON expected staff to alert a licensed nurse if a resident requested to self-administer medications.<br><br>Facility policy, Self-Administration of Medications, revised 6/2017, indicated residents in the facility who wish to self-administer their medications may do so, if it is determined they are capable of doing so. | F 554 | | |
| F 577 SS=C | Right to Survey Results/Advocate Agency Info<br>CFR(s): 483.10(g)(10)(11)<br><br>§483.10(g)(10) The resident has the right to-<br>(i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and<br>(ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.<br><br>§483.10(g)(11) The facility must-- | F 577 | | 8/4/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 577 | Continued From page 7<br>(i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.<br>(ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and<br>(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.<br>(iv) The facility shall not make available identifying information about complainants or residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure three years of survey results were readily accessible for residents and visitors review. This had the potential to affect all 43 residents who resided in the facility and all visitors.<br><br>Findings include:<br><br>On 06/28/21, at 12:33 p.m. a three-ring binder was observed in a wall file, labeled Department of Health Survey Results, opposite the care center entrance area. The binder contained standard survey results dated 3/21/19, and abbreviated survey results dated 10/21/19. However, the results of four abbreviated surveys, two COVID-19 focused infection control surveys, and standard survey results for 7/26/18, all which occurred during the three preceding years, were not available. Additionally, no posted information indicated additional results were available. | F 577 | 1.It is the policy of this facility to abide by state and federal regulations related to resident rights, specifically having readily available the Department of Health survey results for residents, family members and legal guardians to view as necessary. The 3 rings□binder available labeled survey results was updated to contain 3 years of survey results on 6/30/21. The administrative assistant was reminded on 6/30/21 that survey results should be easily accessible according to facility policy Posting Care Center Survey.<br>2.All residents, family members, legal guardians and visitors are potentially affected by the cited deficiency.<br>3.To enhance the Care Center operations and under the direction of the Director of Nursing or designee, the care center leadership, and administrative assistant will be in-service on the requirements of posting survey results. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 577 | Continued From page 8<br>On 6/30/21, at 12:51 p.m. the staffing/billing representative (SR) confirmed that the binder contained only the 3/21/19, and 10/21/19, survey results. SR stated she thought only the most recent annual survey was required and was unaware survey results from the three preceding years needed to be available for residents and visitors review.<br><br>On 6/30/21, at 2:51 p.m. the interim director of nursing (DON) acknowledged that any surveys, certifications, and complaint investigations made regarding the facility during the three preceding years needed to be available for residents and visitors review.<br><br>The facility policy Posting Care Center Survey results dated 07/2021, indicated survey results must be in an easily accessible location, contain survey results, certifications, and complaint investigations made respecting the facility during the 3 preceding years; as well as, any plan of correction. The policy further indicated notice of accessibility to these results should be posted in prominent [sic] and accessible to the public. Additionally, the policy indicated the survey results will be maintained in a binder well labeled "Survey Results" and kept at the main entrance to the Care Center. | F 577 | 4.Social Services or designee will audit survey binder twice monthly for 6 months. Results of the audits will be reported to the QA committee for review and action, as appropriate. The QA committee will determine the need for further audits and/or action plan. | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by: | F 677 | | 8/4/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 677 | Continued From page 9<br>Based on observation, interview and document review, the facility failed to ensure shaving was offered or provided for 2 of 3 residents (R25 and R27) in the sample who were dependent upon staff for assistance with activities of daily living (ADLs).<br><br>Findings include:<br><br>R25's face sheet undated, indicated diagnosis included acute on chronic diastolic (congestive) heart failure, adjustment disorder with depressed mood, major depressive disorder, chronic obstructive pulmonary disease, and anxiety disorder.<br><br>R25's quarterly minimum data set (MDS) dated 5/4/21, indicated moderate cognitive impairment. R25's MDS further indicated need for assistance of one assist for dressing and personal hygiene.<br><br>R25's care plan revised on 6/15/21, indicated the resident has an ADL self-care performance deficit r/t chronic diastolic CHF, hx of bilateral pleural effusion, moderate cognitive deficit. Paroxysmal atrial fibrillation hypertension, 3rd degree av block with pacemaker, hypothyroidism, anxiety and history of depression with interventions listed as the resident preferred dressing/grooming routine is done before breakfast. Personal hygiene: the resident prefers shave every morning. Able to shave on own after set up. Touch up as needed. Clean shaver for the resident.<br><br>During observation and interview on 6/28/21, at 12:42 p.m. R25 was sitting in recliner and had approximately 1/4 inch facial hair covering cheeks, chin, neck, and below nose. Hair appears to be coarse gray/white. R25 stated that | F 677 | 1.It is the policy of this facility to abide by state and federal regulations, specifically ADL care provided for dependent residents. Resident R25, R27 was shaved on 6/30/21, the care plan preferences for shaving were reviewed with R25, R27 on 7/22/21 updated per preference.<br>2.All residents that are dependent and have facial hair are potentially affected by the cited deficiency. Residents that are dependent preferences will be clarified and care plan updated.<br>3.To enhance the Care Center practices and under the direction of the Director of Nursing or designee, the nursing staff will be in-serviced on ADL care provided for dependent residents.<br>4.Director of Nursing or designee will audit resident grooming 3 times per week x 4, then monthly x4. Results of the audits will be reported to the QA committee for review and action, as appropriate. The QA committee will determine the need for further audits and/or action plan. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 677 | Continued From page 10 | F 677 | | |

they are going to help him with shaving today.

During observation on 06/28/21, 7:28 p.m. R25 sitting in his recliner and continued to be unshaven, hair remain approximately 1/4 in. long on face and chin which was, coarse gray/white hair.

During observation and interview on 06/29/21, at 10:02 a.m. R25 was sitting in recliner, remained unshaven with approximately 1/4 in coarse gray and white hair on face, chin and neck. R25 stated "I would like to be shaved some time today".

During interview on 6/29/21, at 12:59 p.m. trained medication aide (TMA)-A stated that R25 is assistance of one for all cares including bathing, dressing, and shaving.

During interview on 6/29/21, at 1:15 p.m. licensed practical nurse (LPN)-A stated R25 does require assistance with cares. LPN-A further stated that R25 can shave himself if someone sets him up to do so. LPN-A stated it is important for men to be shaved if that is their preference as it helps with self esteem and everyone wants to look their best.

During interview on 6/29/21, at 2:15 p.m. nursing assistant (NA)-B stated she had just finished getting R25 cloths changed and was in the process of cleaning up the room. NA-B stated that it was important to shave all men who wanted to be shaved and this would be indicated on the residents care plan. NA-B further stated she had not shaved R25 as she usually does not help with residents getting up in the morning. NA-B further stated she wasn't sure if he was or

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 677 | Continued From page 11 | F 677 | | |

wasn't shaved yet today. NA-B stated being shaved can help the individual feel better. NA-B stated she can go back into room and assist R25 with shaving. NA-B stated if you give him the razor he will usually shave himself and if he refused the nurse should be notified and it should be documented. NA-B went back into R25's room.

During interview on 6/30/21, at 9:37 a.m. NA-C stated that all men should be shaved daily for appearance, if they choose.

R27's Face sheet undated, indicated diagnosis: unspecified dementia with behavioral disturbance, delirium due to known physiological condition, and anxiety.

R27's quarterly MDS dated 5/5/21, indicated moderate cognitive impairment. MDS further indicated R27 requires assistance of one for dressing and personal hygiene which included combing hair, brushing teeth, and shaving.

R27's care plan revised on 11/17/20, indicated the resident has an ADL self-care performance deficit with interventions: the resident prefers dressing/grooming routine is done prior to breakfast.

During observation and interview on 6/29/21, at 12:56 p.m. R27 had approximately 1/4 inch coarse gray/white hair on cheeks, chin, neck, and below nose. R27 stated he wants to be shaved as he likes to have his hair short. R27 was not sure the last time he was shaved.

During observation on 6/29/21, at 9:28 a.m. R27 walking in the hallway with front wheeled walker.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 677 | Continued From page 12 | F 677 | | |

R27 facial hair noted.

During observation on 6/29/21, at 12:16 p.m. R27 walking down hallway continue to have approximately 1/4 in. coarse gray/white hair on face and neck.

During interview on 6/29/21, at 1:28 p.m. license practical nurse (LPN)-A stated R27 requires assistance of 1 with all morning and afternoon cares including shaving and oral cares, which staff should be providing to him.

During interview on 6/29/21, at 2:15 p.m. nursing assistant (NA)-B stated all men should be shaved if that is their preference and should be offered morning and night.

During interview on 6/29/21, at 5:16 p.m. registered nurse (RN)-B stated R27 can shave himself if you cue him. RN-B also stated it is important to assist with grooming as they can't identify the problem themselves and R27 is a very social man and you want him to have good appearance.

During observation on 6/30/21, at 7:14 a.m. R27 was walking down hallway with front wheeled walker and continued to have facial hair on face and neck.

During interview on 6/30/21, at 8:43 a.m. NA-C stated R27 has dementia and needs assistance with shaving. NA-C further stated she had attempted to shave him this morning but his razor was full of hair and needed to find a brush to clean it. NA-C stated all men, if they prefer it, should be shaved daily for appearance and R27 is a social man and it is important to him to have

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 677 | Continued From page 13<br>good appearance. NA-C further stated it appeared R27 has not been shaved for many days which is not ok as he likes his hair short.<br><br>During interview on 6/30/21, at 10:35 a.m. the director of nursing (DON) stated that both men and women should be shaved if they have hair growing and they prefer it to be shaved. DON further stated it is not acceptable for men to not be shaved. DON stated not being shaved can be a dignity issue along with harbor germs as food can get caught in the hair.<br><br>Shaving the resident policy revised 10/2010, indicated "The purpose of this procedure is to promote cleanliness and to provide skin care. Notify the supervisor if the resident refuses the procedure".<br><br>Activities of Daily Living policy expires 6/21, indicated "residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene".<br><br>Care plan-Comprehensive person-centered policy expires 6/21, indicated "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident". | F 677 | | |
| F 684 SS=E | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to | F 684 | | 8/4/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 14<br>facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review the facility failed to follow orders for monitoring weights for 4 of 4 residents (R3, R24, and R25), the facility failed to assess bruising for 1 of 1 residents (R13). In addition, the facility failed to notify provider for 1 of 1 residents (R41) for a blood sugar readings above a specified range.<br><br>Findings include:<br><br>R25's face sheet undated, indicated diagnosis included acute on chronic diastolic (congestive) heart failure, adjustment disorder with depressed mood, major depressive disorder, chronic obstructive pulmonary disease, and anxiety disorder.<br><br>R25's quarterly minimum data set (MDS) dated 5/4/21, indicated moderate cognitive impairment. R25's MDS further indicated need for assistance of one assist for dressing and personal hygiene.<br><br>R25's care plan revised on 6/15/21, indicated the resident has an activity of daily living (ADL) self-care performance deficit r/t chronic diastolic CHF, hx of bilateral pleural effusion, and moderate cognitive deficit. R25's care plan further indicated the resident has congestive heart failure and vital signs should be monitored weekly. | F 684 | It is the policy of this facility to abide by state and federal regulations, specifically quality of care related to following providers orders for monitoring weights, for R3, R24, & R25, notifying the provider for blood sugar reading above the specified range for R41, and assessing a bruise for R13.<br>a.Weights were completed for R3 on 6/29/21, R24 on 6/29/21, R25 on 7/1/21. R3, R24, & R25 was not negatively impacted by the cited deficiency. The dietician was notified on 7/1/21 for R25 change in weight, and responsible party for R25 on 7/2/25, R24 responsible party notified 6/29 & R3 responsible party was notified on 6/30.<br>b.R13 was not negatively impacted by the cited deficiency R13 was assessed on 6/29/21 and responsible party was notified on 6/29/21. Long sleeves shirt was implemented on 6/29/21. Protective sleeves were initiated on 6/30/21 and care plan was updated with protective sleeves to reduce bruising on 7/5/21.<br>c.R41 was not negatively impacted by the cited deficiency R41 responsible party was notified on 6/29/21 and the provider was notified on (6/29/21)<br>1.All residents are potentially affected relative to provider orders and bruising. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 15<br>R25's weight calculations percentage loss on 05/19/2021, the resident weighed 204.6 lbs. On 06/16/2021, the resident weighed 193.3 pounds which is a -5.52 % Loss.<br><br>R25's cardiology note dated 6/4/21, clinical impression included: marked edema with evidence of pulmonary vascular congestion (extra fluid in the lungs), I believe this patient would benefit from increased diuretics, chronic heart failure. Recommendation included changing amlodipine to 10 mg as amlodipine is likely to make his peripheral edema worse. Start zaroxolyn 2.5 mg by mouth every other day in the morning with his Lasix to see if we can reduce his pulmonary congestion and peripheral edema.<br><br>R25's provider orders dated 6/19/21 Lasix (diuretic) 80 mg by mouth every morning for CHF and 40 mg by mouth every evening for CHF.<br><br>Progress note dated 6/23/21, at 11:20 am indicated new order to obtain weights three times per week, one time a day every Monday, Wednesday, and Friday for weight loss and resident is on isolation precautions for C-diff.<br><br>Staff care guide sheets updated 6/29/21, indicated R25 should be weighed on Wednesdays.<br><br>R25's weight list dated 7/1/21, indicated last weight done on 6/16/21 was 193.2. The only other documentation of weight was 5/19/21 which was 209.4 (was in a wheelchair), and 5/17/21 weight was 204.6.<br><br>During interview on 6/29/21, at 12:59 p.m. trained medication aide (TMA)-A indicated resident is to | F 684 | Resident with specified blood sugar ranges is also potentially affected by the cited deficiency.<br>a.Blood sugar parameters were added to residents with specified ranges to create an alert on the dashboard. Nursing leadership will audit dashboard in clinical meeting.<br>b.Skin assessment was completed on all residents on 7/23/21 thru 7/26/21<br>2.To enhance the Care Center clinical practice and under the direction of the Director of Nursing or designee, the nursing staff will be in-serviced on following provider orders for weights, blood sugars with specified ranges, assessing and reporting bruising, and completing weekly skin assessment/documentation.<br>3.Director of Nursing or designee will audit resident with weights ordered more than weekly, blood sugars with specified ranges in daily in clinical meeting with no end date. Five residents will be randomly audited for bruising weekly x4 then monthly x2. Results of the audits will be reported to the QA committee for review and action, as appropriate. The QA committee will determine the need for further audits and/or action plan. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 16 | F 684 | | |

be monitored for weights due to weight loss and his current infection of c-diff. TMA stated the nursing assistants (NA) weigh the residents and mark them on the clipboard the nurses will review and enter into the computer. TMA further stated it was important to weigh residents to make sure they are stable and not losing or gaining to much weight.

During interview on 6/29/21, at 1:15 p.m. licensed practical nurse (LPN)-A stated R25 has a diagnosis of c-diff and staff are monitoring his weights due to weight loss. LPN-A stated right now they have no way of weighing him outside of his room due to being on precautions, however he thinks they could use the hoyer lift and just clean the machine, but has not brought this to the attention of the registered nurses. LPN-A confirmed R25 should be being weighed three times a week Monday, Wednesday and Friday, and stated "It was a nursing order not a provider order". LPN-A stated he was not aware of any weight loss with R25 until he looked into the computer while talking and stated he would classify his weight loss as a significant loss. LPN-A further stated the provider and dietician should be notified as well to further monitor.

During interview on 6/29/21, at 2:15 p.m. NA-B stated R25 should be weighed on his bath days which was Wednesday and then reported to the nurse if he refused. NA-B stated it was important to weigh residents to make sure their weights are stable.

During interview on 6/29/21, at 4:14 p.m. Dietician stated R25 was put on strong diuretics and now has c-diff and it was important to monitor his weights to make sure he has not lost any more

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 17 | F 684 | | |

weight. The dietician stated she sees his weight was up to 204, but he is now back to baseline at 193 and stated they should be monitoring his weight to make sure he is not losing anymore weight. The Dietician stated she sees an order that was put in by nursing on 6/18/21 for three times a week weights and would expect staff to be weighting him.

During interview on 6/29/21, at 4:51 p.m. registered nurse (RN)-A stated in general all residents should be weighed at least weekly, however with R25 there was an order that was just put in for three times a week weights. RN-A stated she would be expecting staff to weigh residents and if they were unable to weigh him that it should be reported to the RN's. RN-A stated it was important to monitor R25's weight as he was on diuretics and due to his nutritional status and c-diff.

During interview on 6/29/21, at 5:05 p.m. RN-B stated R25 should be monitored for weight three times a week and if no specific order all residents should be done once a week. RN-B further stated it is not ok to go a month without being weighed and it is important to monitor his weights due to being on diuretics and c-diff and should monitor for a decline in status.

During interview on 6/30/21, at 10:35 a.m. the director of nursing (DON) stated if a resident has a weight that states three times a week weights, she would expect this resident to be weighed three times a week. DON stated she was not aware that he was not being weighed or had no way of weighing R25 due to precautions. DON stated there are ways to weigh someone on precautions if that meant getting a new mobile

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 18 | F 684 | | |

scale or bringing resident out when no other residents were in the hallway to keep isolation precautions. DON stated it was important to weigh R25 to monitor his status and make sure he is not losing to much weight or regaining weight with the diuretics.

Weight assessment and intervention policy expires 6/21, "The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. Weights will be recorded in each unit's weight record chart or notebook and in the individual's medical record. Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified nursing will immediately notify the dietitian in writing. Verbal notification be confirmed in writing".

R41's Facesheet undated, indicated diagnosis: diabetes type 2 with diabetic polyneuropathy, diabetes mellitus with diabetic chronic kidney disease, and essential hypertension.

R41's quarterly MDS dated 6/3/21, identified no cognitive impairment.

R41's provider orders dated 6/29/21, indicated Novolog FlexPen Solution Pen-injector 100 UNIT/ML (Insulin Aspart) (medication to bring down blood sugar) Inject as per sliding scale: if 0 - 149 = 0; 150 - 200 = 2; 201 - 250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351 - 999 = 10 to Notify MD, subcutaneously before meals and at bedtime related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS (E11.9).

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 19 | F 684 | | |

R41's weights and vital summary dated 6/29/21, indicated blood sugar on 6/28/21 at 12:01 was 442 and then on 6/15/21 at 10:51 pm blood sugar was 411.

During interview on 6/29/21, at 1:05 p.m. LPN-A stated he was aware of R41's blood sugar was 442 on 6/28/21, but stated "I knew it was from R41 eating ice cream and sometimes you have to use your common sense and I did not notify the provider". LPN-A stated you should follow the provider orders however with him it is due to R41's bad habits. LPN-A further stated the providers have access to his point click care and can see his results. LPN-A stated he went down and assessed R41 and he wasn't having symptoms so he gave him his insulin but did not follow the order and notify the provider. LPN-A stated he could not find documentation on 6/28/21 nor 6/15/21 when blood sugars where elevated.

During interview on 6/29/21, at 4:22 p.m. the Dietician reviewed Novolog orders and stated if residents blood sugar was 442 according to providers orders the provider should of been notified and is unacceptable for staff not to notify the provider. The dietician further stated it is important to notify provider of high blood sugars as it could mean their medications need to be adjusted or there is something else going on with the resident.

During interview on 6/29/21, at 5:12 registered nurse (RN)-B stated if a residents blood sugar was 442 she would expect staff to notify the provider and it was unacceptable for the nurse not to notify the provider even if the resident ate ice cream. RN-B stated it was important to follow

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 20 | F 684 | | |

providers orders.

During interview on 6/30/21, at 10:35 a.m. the director of nursing (DON) stated according to R41's Novolog orders any blood sugar over 351 the nurse should be giving him 10 units of insulin and calling the provider. DON stated it is nursing standards to follow provider orders and notify the provider if the order states to or the blood sugar is out of the normal despite R41 having ice cream. DON further stated it was important to notify the provider in case the provider needed to adjust his medication. DON further stated she will be changing the settings for his orders/parameter in point click care as it has the capability to make sure an outcome was completed.

Diabetes-Clinical protocol expires 6/21, indicated " The physician will follow up on any acute episodes associated with a significant sustained change in blood sugars or significant deterioration of previous glucose control and document resident status at subsequent visits until the acute situation is resolved. The physician will order desired parameters for monitoring and reporting information related to blood sugar management. The staff will incorporate such parameters into the medication administration record and care plan. The staff will identify and report issues that may affect, or be affected by a patient's diabetes and diabetes management such as foot infection, skin ulceration, increased thirst, or hypoglycemia. ".

Nursing care of resident with diabetes mellitus expires 6/21, indicated "The management of individuals with diabetes mellitus should follow relevant protocols and guidelines. The physician will order the frequency of glucose monitoring".

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 21 | F 684 | | |

R13's quarterly MDS dated 4/6/21, indicated R13 was severely cognitively impaired, she was sometimes able to make herself understood and sometimes able to understand others. R13's diagnoses included dementia, diabetes, anxiety, hypertension and heart failure. R13 was able to move her upper extremities without limitations.

During observation on 6/28/21, at 12:05 p.m. R13 was noted to have a large bruise on her left arm that started at her wrist and extended to approximately halfway between her wrist and her elbow. The bruise also wrapped around her arm. The bruise was at various stages of healing. Also noted was a large, deep purple bruise starting at the base of her left thumb and extended to the back of her hand. R13 had several smaller, scattered, deep purple bruises on her right arm. R13 was not able to explain how she got the bruises.

Progress notes failed to identify the bruising.

There were no skin assessments completed during 6/2021.

On 6/29/21, at 12:48 p.m. nursing assistant (NA)-A confirmed the bruising on both R13's arms and stated she had previously noted the bruising but was not sure how long they had been there. NA-A explained what she reports to the nurse, when doing daily skin checks, depends on what it is. If it is something that is common for that resident, such as the bruising is for R13, she would first talk with her co-worker, another nursing assistant, to decide if it needs to be reported. NA-A did not recognize the bruising on R13's arms. NA-A was not sure if she would have

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 22 | F 684 | | |

reported this, indicating she would talk with another nursing assistant first. NA-A stated R13 does not become physically aggressive or resistive with cares but does swing her arms around when she gets excited and is happy.

On 6/29/21, at 1:45 p.m. licensed practical nurse (LPN)-A confirmed he was aware of the bruising on R13' arms but was not aware of how they happened. LPN-A confirmed they were not monitoring the bruising or documenting in the progress notes.

On 6/29/21, at 2:09 p.m. LPN-B confirmed the bruises located on R13's arms. She stated, R13 is given her call light, but does not consistently use it. She would often slap her arms to get the staff attention. LPN-B indicated she had made previously made notes regarding R13's bruising and discussions with R13's daughter about the bruising. LPN-B's notes were requested but were not received.

On 6/29/21, at 2:17 p.m. registered nurse (RN)-B stated she expected all skin concerns or changes, including bruising, were reported to the nurse and documented. This included previously reported skin concerns. Reported bruises should be documented in the progress notes with size and appearance. Bruising should then be monitored either daily or weekly, depending on the severity of it. Bruises are investigated to decide the cause and how to avoid recurrence. RN-B indicated she was not aware of R13's bruises on her arms, but confirmed size, location and varied stages of healing.

On 6/30/21, at 1:50 p.m. director of nursing (DON) stated anything that was seen, new or

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 23 | F 684 | | |

existing, needed to be documented, even if it is a bruise that is fading. DON expected bruising with a known cause is still investigated and documented. If a resident bruises easily, then need to determine the cause so changes can be made to prevent bruising.

A facility policy regarding skin checks was requested but was not received.
R3's face sheet undated, indicated diagnoses included morbid obesity with alveolar hypoventilation (slow/shallow breathing), localized edema, unspecified diastolic (congestive) heart failure, pulmonary hypertension, type 2 diabetes mellitus with diabetic neuropathy, schizophrenia, borderline personality disorder, and anxiety disorder.

R3's quarterly minimum data set (MDS) dated 3/11/21, indicated cognition intact. R3's MDS further indicated need for extensive assist of one for bed mobility, transfers, ambulation, dressing, toilet use, and personal hygiene.

R3's care plan revised on 3/27/19, indicated resident on diuretic therapy and hypertension (HTN) medications r/t edema, HTN, chronic kidney disease (CKD) and poor circulation. R3's care plan further indicated resident monitored for side effects and effectiveness, wt. (weight) and vital signs (VS) at least weekly or per order and prn (as needed), and MD updated of excessive wt. gain or abnormal VS from resident's baseline.

R3's signed provider order summary dated 5/13/21, indicated weight one time a day every Monday, Wednesday, Friday related to localized edema.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 24 | F 684 | | |

R3's signed provider order summary dated 5/13/21, indicated metolazone (diuretic) 2.5 mg by mouth one time a day every Mon, Wed, Fri related to localized edema was initiated 11/13/17. Additionally, provider order dated 1/24/20, bumetanide (diuretic) 1 mg by mouth two times a day related to unspecified diastolic (congestive) heart failure.

R3's weight summary dated 7/1/21, indicated documented weights from the last six months were obtained 1/8/21, 1/19/21, 1/22/21, 1/29/21, 2/2/21, 2/5/21, 2/9/21, 2/16/21, 2/23/21, 3/2/21, 3/5/21, 3/9/21, 3/12/21, 3/16/21, 3/23/21, 3/26/21, 3/31/21, 4/8/21, 4/9/21, 4/13/21, 4/20/21, 4/27/21, 5/4/21, 5/5/21, 5/7/21, 5/11/21, 5/18,21, 5/25/21, 6/1/21, 6/8/21, 6/15/21, and 6/29/21.

During interview on 6/30/21, at 9:29 a.m. licensed practical nurse (LPN)-B stated that R3 had her weight taken on Tuesdays. As LPN-B reviewed R3's electronic health record (EHR), LPN-B stated "I see the order now for Monday, Wednesday, Friday. It needs to be adjusted." LPN-B further stated R3 wanted to be weighed only one time a week and the management of weights was "overall a team effort".

During interview on 6/30/21, at 11:13 a.m. registered nurse care manager (RN)-A stated the charge nurse monitored weights. RN-A further stated the charge nurse reviewed resident orders prior to provider visits to ensure order changes were requested, and weights were reviewed at standup meetings. RN-A further stated if provider orders were not followed, it would be "written up",

During interview on 6/30/21, at 2:51 p.m. interim director of nursing (DON) stated staff were

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 25 | F 684 | | |

expected to follow provider orders for weights and nurses were expected to monitor weights. The DON further stated if a resident refused to be weighed, she would expect the nurse to completed an assessment and notified the provider after the resident's third refusal. Additionally, the DON stated she expected orders to be followed as written until they were discontinued or changed.
R24's quarterly MDS dated 4/29/21, indicated R24 was cognitively intact, used a walker or wheelchair for locomotion, and required limited assistance/supervision with walking and toileting. The MDS identified diagnoses which included congestive heart failure, high blood pressure, kidney failure, and dementia.

R24's care plan dated 2/14/21, included an intervention to weigh R24 as ordered by provider which was to be completed at the same time under the same conditions with same amount of clothing.

R24's order summary report contained a provider order for daily weights relating to diagnosis of congestive heart failure with a start date of 1/26/21, and no end date.

R24's treatment administration record (TAR) lacked documentation of daily weights on 30 of 104 days between 2/15/21, and 6/28/21. No explanation of missing values were recorded on R24's progress notes.

During interview on 6/30/21, at 2:51 p.m. DON stated she expected provider orders to have been followed. She stated if the TAR noted a task was complete she expected it to have been completed otherwise it would be considered falsification.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 26<br><br>DON reviewed R24's daily weight documentation and stated she observed gaps. She reviewed the TAR and acknowledged there were more weights documented as having been completed than were recorded in R24's vital sign documentation. She stated they [staff] signed off something that was not completed, and her expectation was weights would be recorded and signed off only when completed. | F 684 | | |
| F 689 SS=J | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to establish adequate protective measures and supervision to ensure residents who were dependent on oxygen did not smoke while using portable oxygen for 1 of 4 residents (R23) who were listed as smokers in the facility. The deficiency was issued at Immediate Jeopardy (IJ) level as R23 remained at risk for significant injury or death related to smoking while oxygen was in use.<br><br>The IJ began on 6/29/21, at 10:49 a.m. when R23 was observed smoking a cigarette in the designated smoking area while using a portable oxygen concentrator via nasal cannula and the | F 689 | 1.It is the policy of this facility to abide by state and federal regulations, to ensure the resident environment remains free of accidental hazards as is possible. In addition, we commit to provide supervision and assistive devices to prevent accidents. The following was completed on 6/29: cigarettes/lighter was removed from resident R23 possession, R23 was educated on risk of smoking with oxygen & having nasal cannula in place, R23 care plan updated to reflect oxygen/nasal cannula will remain in resident□s room while smoking, smoking assessment was completed on 4 | 8/4/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 27<br>oxygen was observed to be turned on. Smoking cigarettes in conjunction with using oxygen can rapidly accelerate combustion. This could result in significant injury or death to the residents, staff, and visitors in the area. The Administrator and Director of Nursing (DON) were notified of the immediate jeopardy at 1:36 p.m. on 6/29/21. The immediate jeopardy was removed on 6/30/21, at 1:38 p.m. but non-compliance remained at an isolated scope and severity which indicated no actual harm with potential for more than minimal harm (Level D).<br><br>Findings include:<br><br>R23's quarterly Minimum Data Set (MDS) dated 4/28/21, included R23 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating R23 was cognitively intact. R23 required extensive assistance with activities of daily living, locomotion via wheelchair, and was dependent on oxygen. The quarterly MDS lacked documentation of R23's tobacco status. R23's face sheet identified diagnoses included respiratory failure, heart failure, and chronic obstructive pulmonary disease.<br><br>R23's care plan revised 2/15/21, reported R23 had limited physical mobility, used a wheelchair, and was dependent on staff for mobility/wheeling to and from all destinations. R23 required use of continuous oxygen (O2) and became short of breath with exertion, even when talking. The care plan indicated R23 was able to make needs known. The smoking focus area of the care plan indicated R23 smoked three to four times per day and was O2 dependent. A goal revised 2/12/20, listed R23 would smoke without supervision or injury, follow guidelines, and smoke in designated | F 689 | residents, R23 provider was notified of incident,<br>2.All residents, visitors, or staff within 15 feet of oxygen in use with a combustible are potentially affected.<br>3.Smoking policy was revised to address no oxygen use during smoking.<br>Staff-Education initiated on 6/29/21 that included: no oxygen equipment on/off including resident□s wearing nasal cannula/mask should not be within 15 ft of flames including cigarette products, lighters/vape pens, residents that smoke requires a smoking assessment with changes in condition to include functionality, initiation of oxygen and/or changes in oxygen therapy and education on following resident□s plan of care. Education added to new employee orientation.<br>4.DON/ Designee will complete audits of residents that smoke for changes in condition/functionality & oxygen therapy initiation in clinical meeting weekly with no end date. The resident that require supervision has been randomly audited, which was initiated on 7/1/21 to ensure staff compliance with policy and resident care plan that oxygen be left in her room. Audits will continue twice weekly x4 then monthly x2. Results of the audits will be submitted to the QA committee for evaluation and updates. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 28 | F 689 | | |

areas. Interventions revised 2/11/21, included staff were to assist R23 to smoking location, ensure O2 was turned off, and remove the nasal cannula prior to R23 lighting a cigarette. Upon returning to resident, staff were to immediately apply nasal cannula and turn the O2 concentrator on. The care plan identified R23 could light and extinguish her own cigarettes, and keep lighter and cigarettes on self.

R23's Smoking Safety Screen assessment dated 4/28/21, at 3:20 p.m. indicated R23 had no cognitive loss, visual deficits, or dexterity problems. The assessment indicated R23 was capable of lighting her own cigarette, required assistance getting to and from the smoking area, and did not need the facility to store her lighter and cigarettes. A note on the assessment read, "IDT [interdisciplinary team] feel the resident is A/O [alert and oriented], cognitively intact. Able to light cigarette on own. Can control ashes from cigarette. Understands location where smoking is allowed. Needs assistance to get to/from designated smoking area. Understands O2 must be off when smoking." Conditions also included in the assessment read, "Will request to smoke. Staff will escort the resident to the smoking area. Turn off oxygen. Will use Walkie Talkie or phone to alert staff when would like to come in. Staff will turn O2 back on. Staff escort back into building. Has compact O2 able to apply per self, aware of not to use when smoking."

R23's electronic health record contained a provider orders dated 8/27/20, for O2 up to 5 liters per minute, per nasal cannula via concentration, and to keep O2 saturation between 88 and 94%.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 29 | F 689 | | |

During observation on 6/28/21, at 5:57 p.m. R23 was in her room, sitting in wheelchair. No burn holes or heat damage were noted on her clothing.

When interviewed on 6/28/21, at 5:58 p.m. R23 stated she smoked at least once per day, but occasionally went out to the smoking area just to sit while using oxygen. R23 stated she took her portable O2 concentrator with her, turned it off when she smoked, and turned it back on after she put out her cigarette. She stated she kept her cigarettes and lighter with her, but relied on staff to transport her to the smoking area as she was unable to move her wheelchair independently.

During interview on 6/29/21, at 9:44 a.m. certified nursing assistant (NA)-F stated anyone who smoked was assessed to make sure they were safe. She stated R23 needed help to get to the designated smoking area but could smoke independently. NA-F stated the O2 concentrator was powered on until R23 arrived at the smoking area. Once there, staff turned off the O2, removed the nasal cannula, and hung the tubing on the back of the resident's wheel chair. She stated residents were given a 'walkie' and called for staff assistance when they wanted to leave the smoking area.

During observation 6/29/21, at 10:28 a.m. R23 was smoking in the designated smoking area with a nasal cannula in her nose. R23's oxygen concentrator was off and placed on a chair to the resident's left side. R23 had a lit cigarette in her right hand. R23 placed her cigarette in the cigarette receptacle with her right hand and immediately turned on the oxygen concentrator with her left hand. R23 remained in the designated smoking area with another resident

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 30 | F 689 | | |

who was smoking within six feet of R23 and the oxygen concentrator. There was one other resident and a visitor also present, neither were smoking.

During a subsequent observation on 6/29/21, at 10:49 a.m. director of nursing (DON) and registered nurse (RN)-B were brought to the smoking area. R23 had a lit cigarette in her right hand. Her oxygen concentrator was turned on as indicated by the digital display on the unit. The oxygen tubing was connected to the unit and the cannula was in R23's nose. Another resident sat approximately 5 feet from R23 with a lit cigarette. The two residents were facing each other. DON confirmed the concentrator was turned on and immediately turned it off. DON provided immediate education to R23 regarding smoking when wearing O2 was a safety hazard. DON requested R23 remove the nasal cannula, however R23 refused. DON requested all smoking materials from R23 but R23 refused. R23 stated she was not previously told to remove her nasal cannula when smoking. R23 then placed her cigarette in the receptacle, refused DON's offer to transport her into the facility, and called for alternate assistance to go back into to the building. R23 remained supervised by DON and RN-B until 10:53 a.m. when NA-G arrived. NA-G returned R23 to her room at 10:57 a.m.

When interviewed on 6/29/21, at 10:53 a.m. DON stated wearing O2 while smoking was unacceptable. Her expectation was residents removed the nasal cannula prior to smoking. She stated her preference was oxygen was not brought to the smoking area at all. DON confirmed R23 was re-educated immediately regarding the dangers of smoking with O2. R23

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 31 | F 689 | | |

agreed to remove the O2 cannula when going out to smoke, but still requested the oxygen concentrator remain with her when she went to smoke. DON stated R23 needed to be reassessed with new interventions placed for safety.

R23's progress note dated 6/29/21, at 11:18 a.m. identified, "Reported by staff that resident was outside in the designated smoking area visiting with surveyor and she lit a cigarette while she had oxygen on. Resident interviewed in her room and she was tearful stating she had finished her cigarette and turned her oxygen on while still outside visiting. She states she forgot the oxygen was on and lit a cigarette and didn't realize until she had taken two puffs. Reviewed smoking policy with resident and another nurse present. Explained to resident that plan would now change and she would have supervision with smoking and that smoking supplies would be kept at the nurse's desk. Oxygen concentrator and tubing would not be taken outside to smoking area. Resident became upset, raising voice at nurse stating,'What kind of prison is this!' 'You can't take my cigarettes from me!' Risk for injury, burns, explosion, and possible death explained to her as it has been done in the past. Resident crying and telling staff that they are abusing her. Resident did calm down with 1:1 and gave nurse her lighter and four cigarettes. Stated she did not have anymore in her room. Staff updated on new smoking plan, resident will be supervised with smoking, concentrator and tubing will be left in her room."

The facility Smoking Policy last revised 7/18 with expiration of 7/19 outlined expectations for patients, tenants, visitors, and employees. The

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 32 | F 689 | | |

policy identified the designated smoking areas for visitors and long term care (LTC) center residents were in the LTC center parking lot on the west side near the kitchen entrance, and on the South end of the west parking lot near the street or dumpster, and on the west end of the parking lot under the shade tree. The policy lacked direction for safe smoking assessment, and further lacked any requirement to remove oxygen prior to smoking. No additional policies or procedures related to smoking safety or unsupervised smoking were provided.

The Smoking Safety Screen dated 6/29/21, at 11:47 a.m. identified R23 was reassessed safe to smoke with supervision and one-to-one assistance. The facility would store R23's lighter and cigarettes.

During continuous observation on 6/30/21, at 12:52 p.m. R23 put on her call light. NA-K entered R23's room, removed R23's nasal cannula and concentrator from her wheelchair then pushed R23 to the nursing station. NA-K checked R23's oxygen saturation level, retrieved a bag containing R23's smoking supplies from the medication room, and gave it to R23. NA-K transported R23 to the designated smoking area where R23 smoked a cigarette accompanied by NA-K.
-At 1:03 p.m. NA-K was replaced by NA-F.
-At 1:12 p.m. R23 placed her cigarette in the receptacle and requested to return to her room. NA-F transported R23 to the nursing station, checked R23's O2 saturation level, placed the bag with R23's lighter and cigarettes in the medication room, and returned R23 to her room where NA-F placed the nasal cannula on R23 and turned on the oxygen. R23 was never left

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 33<br>without staff supervision.<br><br>The immediate jeopardy that began on 6/29/21, was removed on 6/30/21, at 1:38 p.m. when it was verified, based on observation and interview that the facility successfully implemented a removal plan which included the following:<br><br>Staff were educated regarding:<br>-The change in R23's smoking supervision requirement<br>-Removal of R23's nasal cannula and oxygen concentrator prior to transportation to the designated smoking area<br>-Facility storage of R23's cigarettes and lighter<br>-Monitoring R23's O2 saturation levels both before and after smoking<br>-All cigarettes and lighters were removed from R23's possession. R23 was re-educated regarding the risk of smoking with oxygen, and care plan was updated to reflect oxygen and nasal cannula will remain in R23's room while smoking.<br>-All residents who smoked, including R23, were re-assessed for safe smoking.<br><br>The facility smoking policy was reviewed for adequacy and updated to include LTC residents will have a smoking assessment on admission, initiation of smoking after admission, quarterly, and any changes of condition which include functionality. Education on smoking cessation should be addressed with each assessment and documented. Smoking materials and any other source of ignition should be kept at least 15 feet (4.3 meters) away from an oxygen-enriched atmosphere such as a resident receiving oxygen via nasal cannula, oxygen mask or other delivery device. All smoking materials will be stored in the | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 34<br>medication room for residents who require oxygen. Oxygen, nasal cannula and mask will remain in the resident's room while smoking in the designated smoking area. Residents who require supervision will be accompanied by staff to the smoking area and remain with the resident for the duration of the smoke break. Residents without the dexterity to hold a cigarette will be prohibited from smoking. The need for supervision or independent will be reflected in the smoking assessment, addressed in the care plan, and updated when indicated. The care center reserves the right to prohibit smoking when there is imminent threat to patient safety. | F 689 | | |
| F 732 SS=C | Posted Nurse Staffing Information<br>CFR(s): 483.35(g)(1)-(4)<br><br>§483.35(g) Nurse Staffing Information.<br>§483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:<br>(i) Facility name.<br>(ii) The current date.<br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>(A) Registered nurses.<br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>(C) Certified nurse aides.<br>(iv) Resident census.<br><br>§483.35(g)(2) Posting requirements.<br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br>(ii) Data must be posted as follows: | F 732 | | 8/4/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 732 | Continued From page 35<br>(A) Clear and readable format.<br>(B) In a prominent place readily accessible to residents and visitors.<br><br>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to post daily nurse staffing information in an easily accessible location. This had the potential to effect all 43 current residents, their families, and visitors.<br><br>Findings include:<br><br>During interview on 06/30/21, at 10:51 a.m. the staffing representative stated the staff posting was located on a clipboard behind the nurse's station. She presented the daily assignment sheet but was not aware of any posting for residents which included staff times and census.<br><br>During observation on 6/30/21, at 10:52 a.m. the cork board on the wall to the right of the ADON office door was empty.<br><br>During interview on 6/30/21, at 10:52 a.m. licensed practical nurse (LPN)-B stated the staff posting should have been on a cork board on the | F 732 | 1.It is the policy of this facility to abide by state and federal regulations by posting nursing staff data in a prominent place readily accessible. The required staffing information was posted on 6/30/21 after speaking with the surveyor.<br>2.All residents, family members, legal guardians and visitors are potentially affected by the cited deficiency.<br>3.To enhance the Care Center operations and under the direction of the Director of Nursing or designee, the nursing staff will receive an in-service on posting the required staffing information daily.<br>4.Director of Nursing or designee will audit staff posting daily x7 for 2 weeks, weekly x4, then monthly x2. Results of the audits will be reported to the QA committee for review and action, as appropriate. The QA committee will determine the need for further audits and/or action plan. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 732 | Continued From page 36<br>wall to the right of the assistant director of nursing (ADON) office above a sofa. She acknowledge it was not there, and stated it should have been done by the night staff, the ADON, or the director of nursing (DON). She stated there was always something posted there but she had not paid attention to it.<br><br>During interview on 6/30/21, at 11:01 a.m. DON stated she did not know where the staff posting was. She stated it was important to provide this information in an easily accessible place so residents knew who was assigned to them. The DON acknowledged the staffing information was not posted and indicated concern over lack of accessibility due the sofa underneath. | F 732 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of | F 761 | | 8/4/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 761 | Continued From page 37<br>the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review the facility failed to ensure medications available for use in a medication cart were appropriately labeled with an opened date in 2 of 2 medication carts reviewed for medication storage.<br><br>Findings include:<br><br>R40's face sheet dated 6/30/21, indicated R40's diagnosis included dementia and glaucoma.<br><br>R40's medication administration record (MAR) for 6/1/21-6/30/21, indicated R40 received scheduled eye drop, Azopt Suspension 1% to both eyes two times daily for glaucoma.<br><br>On 6/29/21 at 4:35 p.m., licensed practical nurse (LPN)-A and surveyor observed R40's Azopt Suspension 1% were opened, in the cart. There was no opened date on the prescription label or on the medication bottle. According to the pharmacy label, this medication was filled on 5/28/21.<br><br>On 6/29/21, during medication cart inspection, LPN-A stated it was expected that an open date is written on the pharmacy label when eye drop bottles are first opened and used. The reason to date the label is because eye drops have an expiration date and are not supposed to be | F 761 | 1.It is the policy of this facility to abide by state and federal regulations related to storage of drugs and biologicals. A complete audit was completed on both medication carts; eye drops without an open date was discarded and reordered. R40 was not negatively impacted by the cited deficiency.<br>2.All residents receiving eye drops are potentially affected by the cited deficiency.<br>3.To enhance the Care Center clinical practice and under the direction of the Director of Nursing or designee, an in-service will be completed with license nurses and TMA□s on applying an open date for eye drops. Use after open date should not exceed 28 days and risk associated with exceeding 28 days.<br>4.Director of Nursing or designee will audit medication cart weekly x4, then monthly x3. Results of the audits will be reported to the QA committee for review and action, as appropriate. The QA committee will determine the need for further audits and/or action plan. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 761 | Continued From page 38<br>administered after that date. LPN-A was not certain what the expiration date after opening was for Azopt but thought most eye drops were good for 28 days after they were opened. LPN-A confirmed there were no other opened bottles of Azopt solution 1% for R40.<br><br>On 6/30/21, at 3:32 p.m. pharmacy consultant (PC)-A indicated eye drops needed to be dated when opened. The risk of bacterial growth increased the longer the bottle was used after it was opened. There was an increased risk of infection if the eye drop was used after the expiration date. PC-A stated Azopt eye drops should be stopped no more than 28 days after they are opened.<br><br>On 6/30/21, at 2:00 p.m. director of nurse (DON) stated she expected eye drops were labeled when opened. Unlabeled eye drops were unacceptable.<br><br>Facility policy, Labeling of Medication Containers, last revised 7/2019, indicated the medication label should include the expiration date when applicable, but did not address the need to label eye drops with the open date. | F 761 | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State | F 812 | | 8/4/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 812 | Continued From page 39<br>and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review the facility failed to make sure the fans in the kitchen were properly cleaned and free of dust which had the potential to affect all 43 residents in the facility.<br><br>Findings include:<br><br>During observation on 6/28/21, at 10:29 a.m. thick dust/debris was observed on black oscillating fan that was blowing towards the steam table and prep counters.<br><br>During interview on 6/28/21, at 10:29 a.m. cook-A stated it was not sanitary to have dust on fan, she is not sure who cleans it.<br><br>During interview on 6/28/21, at 10:52 a.m. staffing rep (assisting with dietary) observed the fan and stated that she sees a lot of lint/debris on the fan and further stated it was not ok for that fan to be blowing in the kitchen as it is a fire hazard and not sanitary to be blowing the dust onto the serving areas. Staffing rep stated she was unsure who cleans the fan as she is not sure the facility provided the fan or if it was a staff members. | F 812 | 1.It is the policy of this facility to abide by state and federal regulations related to food safety. The black oscillating fan was removed from the kitchen after speaking with surveyor.<br>2.All residents, family members, legal guardians and staff that consume food from the kitchen are potentially affected by the cited deficiency.<br>3.To enhance the Care Center practices and under the direction of the Dietary Manager or designee, dietary staff will receive an in-service on 7/30/21 ensuring equipment is thoroughly cleaned after each use.<br>4.Dietary Manager or designee will randomly audit kitchen equipment weekly x4 then monthly x3. Results of the audits will be reported to the QA committee for review and action, as appropriate. The QA committee will determine the need for further audits and/or action plan. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 812 | Continued From page 40<br><br>During interview on 6/29/21, at 4:08 a.m. the dietician stated it is not acceptable to have a fan that was caked with dust in the kitchen, as it could contaminate the food sources.<br><br>Infection prevention and control (Dietary) policy revised 9/2016, indicated the purpose "To prevent and control contamination and the spread of infection within the dietary department" "All equipment shall be thoroughly cleaned after each use" | F 812 | | |
| F 880 SS=F | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; | F 880 | | 7/30/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 41<br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review. | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 42<br>The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure appropriate personal protective equipment including surgical masks and eye protection was worn by staff having direct contact with residents. This had the potential to affect all residents residing in the facility. The facility also failed to ensure proper hand hygiene when handling oral medications for 1 of 5 residents (R5) observed during medication administration.<br><br>Findings include:<br><br>R5's Minimum Data Set (MDS) dated 3/24/21, indicated R5 had moderate cognitive impairment and was usually able to understand others. R5's diagnosis included Parkinson's, Schizoaffective Disorder and Bipolar.<br><br>On 6/29/21, at 5:23 p.m. during medication pass observation, TMA-A was observed returning to the medication cart after administering oral medications to another resident, she did not wash her hands or use hand sanitizer upon returning to the medication cart. TMA-A used the computer mouse to document administration of those medications and to look up R5's scheduled medications. She then removed keys from her pocket. She used the keys to open the medication cart, then returned the keys to her pocket. TMA-A opened the medication drawer then removed three cards containing oral medications from the medication cart and placed them on the top of the cart. She then opened the top drawer of the medication cart and removed an oral inhaler and placed it on the top of the cart. | F 880 | 1.It is the policy of this facility to abide by state and federal regulations related to maintain an infection prevention and control program designed a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. TMAs were reminded on 6/30/21 to perform hand hygiene before and after administering medication to a resident, before and after removal of gloves, and medications should not be touched with bare hands. In addition, all staff was provided surgical mask and eye shields on 6/30/21. No resident nor R5 was not negatively affected by the cited deficiencies<br>2.All residents have to the potential to be affected by the cited deficiencies related to hand hygiene and personal protective equipment (PPE).<br>3.To enhance the Care Center infection control program and under the direction of the Director of Nursing, and Infection Preventionist, the interdisciplinary team completed an RCA on 7/20/21 that identified cause of the cited deficiencies. In addition to the following:<br>a.Hand Hygiene policy was reviewed and revised on 7/22/21, a policy & procedure was developed and implemented for surgical mask and policy & procedure for eye protection based on risk assessment.<br>b.All Care Center staff that may enter a resident□s room or encounter a resident | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 43<br>She grabbed a plastic medication cup and placed it on the top of the medication cart. TMA-A grabbed the top medication card in her right hand, placing her left hand under the card. She then pushed the oral medication through the card and into the palm of her ungloved left hand. She then placed the medication in the medication cup on the cart. TMA-A repeated this action with the two other oral medications. TMA-A then returned the three medication cards to the drawer and locked the medication cart. She used the mouse to lock the computer screen. TMA-A then used a spoon to put applesauce into another plastic medication cup. The two cups, with the oral medications and the applesauce, and the oral inhaler were brought into R5's room.<br><br>On 6/29/21, at 5:28 p.m. TMA stated it is automatic that she punched the oral medications out of the medication card and into her ungloved hand, that she had never been told to not punch pills out into her hand. TMA-A confirmed she did not wash her hands or use hand sanitizer when returning to the medication cart.<br><br>On 6/30/21, at 2:00 p.m. director of nursing (DON) stated it is expected hand hygiene is performed, whether with soap and water or using hand sanitizer, between each resident. It is expected medications are punched into the medication cup, not into the staff's hand.<br><br>Facility policy for hand hygiene during medication pass was requested but was not received.<br><br>PPE<br>On 6/28/21, at 5:15 p.m. nursing assistant (NA)-D was observed wearing a cloth face mask. NA-D was observed going in and out of residents' | F 880 | within the facility will be in-serviced on hand hygiene, standard infection control practices, transmission based-precautions, and appropriate PPE use. Understanding & retention of the material will be validated and documented with competency and demonstration. In addition, TMAs will have direct observation with medication administration following hand hygiene training by a license nurse.<br>4.Director of Nursing, Infection Preventionist or designee will audit hand hygiene & proper PPE use all shifts everyday x 1 week, once 100% compliance is achieved audits will decrease to all shifts 5 days per week x2, then all shifts twice per week x4, then each shift monthly x2. Results of the audits will be reported to the QA committee for review and action, as appropriate. The QA committee will determine the need for further audits and/or action plan. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 44 | F 880 | | |

rooms and interacting face-to-face with residents. During interview NA-D stated the cloth mask he currently had on is the one he has been using since he started approximately two months prior. NA-D indicated no one had told him he was not able to wear a cloth masks and he had seen several other staff also wearing cloth masks. NA-D provided assurance that he is washing the cloth mask after each shift he works. NA-D confirmed he worked with a variety or residents and provided personal cares several times throughout each shift worked. He has worked each unit of the facility, while wearing the cloth mask.

On 6/29/21, at 10:25 a.m. housekeeping (HSKP)-A stated cloth masks are allowed now because the risk are low enough in the county. HSKP-A was not sure what the actual number was, "I think they are just allowing it." HSKP-A stated there was no communication or training put out regarding the face masks, but it was assumed that cloth face masks were allowed.

On 6/29/21, at 1:56 p.m. NA-E was observed wearing a cloth face mask. NA-E stated he washes the face mask, "every now and then." NA-E was not sure what the cloth face mask was able to filter out and confirmed there was not a removable/changeable filter inside the mask. NA-E indicated no one had told him he needed to wear a surgical mask, "as far as I know they are fine with us having these masks on." NA-E confirmed he had surgical masks available to him, but he preferred the cloth mask because it was thicker. NA-E confirmed he has worked all units within the facility and has provided care to residents which included assisting with a variety of personal cares.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 45<br><br>On 6/29/21, at 2:01 p.m. registered nurse (RN)-C was interviewed about staff who assist residents with person cares wearing cloth face masks. RN-C responded, "they are wearing a facial covering. They do wash it." He was not aware of staff were required to wear surgical masks versus cloth masks. RN-C confirmed, they are not currently experiencing a shortage of personal protective equipment, which included surgical masks. RN-C confirmed information found on facility document, COVID-19 AAH Mask wearing update, dated 6/15/21, indicated all employees must wear a well-fitting cloth or surgical mask when working in common areas. RN-C was not sure what source this guidance was from, but also confirmed a link was referenced on the document to a Minnesota Department of Health website.<br><br>COVID-19 Recommendations for Health Care Workers, dated 5/10/21, indicated unvaccinated and fully vaccinated health care workers (HCW) should continue to wear a medical-grade facemask and eye protection while at work for source control.<br><br>On 6/28/21, at 4:12 p.m. nursing assistant (NA)-G was observed at nursing station wearing a mask covering only his mouth. ADON was also present wearing a cloth mask. Neither wore eye protection nor had it on their person.<br><br>On 6/29/21, at 9:05 a.m. NA-B was observed wearing a surgical mask. No eye protection was | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 46 | F 880 | | |

observed

During interview on 6/29/21, at 9:06 a.m. NA -B stated the need for personal protective equipment was based on the county positivity rate, and the facility communicated the information to staff via mass text. She stated if a resident was in quarantine she would wear an N95 mask, otherwise a surgical mask was required. She stated eye protection was not required.

On 6/29/21, at 09:26 a.m. activities staff member (AS)-A was observed wearing a floral disposable mask. Eye protection was neither worn nor on her person.

During interview on 6/29/21, 09:26 a.m. AS-A stated she ordered her masks online and preferred them as they were not as 'fibery'. She stated there was no way to know which staff or residents were vaccinated therefore all were treated with the same standard precautions.

On 6/29/21, 09:44 a.m. NA-F was observed wearing a surgical mask. Eye protection was neither worn nor on her person.

During interview on 6/29/21, at 09:44 a.m. NA-F stated the facility provided masks for staff, but staff were not required to wear eye protection.

On 6/29/21, at 12:50 p.m. NA-G was observed wearing a mask covering only his mouth. Eye protection was neither worn nor on his person.

During interview on 6/29/21, at 12:50 p.m. NA-G stated he used to wear eye protection when there was COVID-19, but stated it was now optional. He also stated he was allowed to wear his mask

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 47 | F 880 | | |

under his nose when not with a resident because he was vaccinated against COVID-19, as evidenced by a red tag on his name badge. He stated if staff are vaccinated they can remove masks when around other vaccinated staff.

During observation on 6/30/21, at 7:32 a.m. NA-J was at the nursing station wearing a cloth mask. Eye protection was neither worn nor on her person. Two boxes of masks and one box of eye protection were available on the counter at the nursing station.

During observation on 6/30/21, at 7:33 a.m. DON was wearing a cloth mask. Eye protection was neither worn nor on her person.

During observation on 6/30/21, at 7:35 a.m. TMA-B was not wearing eye protection, nor was it on her person.

During interview on 6/29/21, at 2:34 p.m. infection preventionist RN-C stated staff with a red tag on their name badge were vaccinated, and unvaccinated staff should have been wearing eye protection. He stated he could not require them to wear the tag, but most vaccinated staff wore it. He stated he would change the policy to indicate staff must wear surgical masks and cannot wear home made or cloth masks. He stated he did not know if the floral disposable masks were surgical, but the facility had plenty of masks for staff.

During interview on 6/30/21, 11:35 a.m. infection preventionist RN-C stated CMS determined the county had a moderate COVID-19 transmission level which warranted the use of eye protection by staff for patient care encounters.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 48<br>The facility did not meet the criteria to remove eye protection as outlined in the Minnesota Department of Health guidance COVID-19 Universal Eye Protection Risk Assessment for Long-term Care and Assisted Living-type Settings dated 6/25/21. | F 880 | | |
| F 883 SS=D | Influenza and Pneumococcal Immunizations<br>CFR(s): 483.80(d)(1)(2)<br><br>§483.80(d) Influenza and pneumococcal immunizations<br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure | F 883 | | 8/4/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 883 | Continued From page 49<br>that-<br>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to offer and/or provide pneumococcal vaccinations as recommended by the Centers for Disease Control (CDC) for 2 of 5 residents (R23, R36) reviewed for pneumococcal vaccinations.<br><br>Findings include:<br><br>The CDC guideline, Pneumococcal Vaccine Timing for Adults, dated 6/25/20, indicated persons with medical conditions including chronic heart disease, lung disease, or diabetes who were given one dose of PPSV23 under age 65 | F 883 | 1.It is the policy of this facility to abide by state and federal regulations related influenza and pneumococcal vaccine, specifically ensuring residents if medically indicated can receive the pneumococcal vaccine when indicated based upon age, previous vaccination and/or diagnosis. R23 was not negatively impacted by the cited deficiency and received the pneumococcal vaccine on 7/14/21.<br>2.A total census audit was completed on 7/9/21. A total of 11 residents were identified to receive the pneumococcal vaccine. Any refusal of vaccine will be | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 883 | Continued From page 50<br>should be given either:<br>1) a second dose after age 65 at least five years after the first dose if PCV13 is not given, or<br>2) a dose of PCV13 at age 65 or older at least one year after the PPSV23, followed by a final dose of PPSV23 at least one year after the PCV13 and at least 5 years after the most recent dose of PPSV23.<br><br>The guidelines further indicated for persons given a dose of PCV13 over the age of 65, then give PPSV23 at least one year after PCV13.<br><br>R23's quarterly Minimum Data Set (MDS)dated 4/28/21, indicated R23 was re-admitted 4/2/21, with diagnoses of chronic lung disease, heart failure, high blood pressure, and anemia. R23's was age 66. The MDS also identified R23 was cognitively intact, and R23's pneumococcal vaccination was not up to date, however the facility indicated on the MDS the vaccine was offered and declined.<br><br>R23's facility Immunization Record dated 6/30/21, indicated R23 received the PPSV23 vaccine on 11/17/2012 at the age of 57. R23 was overdue for either 1) a second dose of PPSV23, or 2) a dose of PCV13.<br><br>R23's medical record lacked documentation of screening, education, contraindication, consent, or refusal for either the PPSV23 or the PCV13 vaccination.<br><br>R36's quarterly MDS dated 5/26/21, indicated R36 was first admitted 2/22/18, with diagnoses including diabetes, heart disease, and stroke. R36's was age 72. The MDS also identified R36 had moderate cognitive impairment and R36's | F 883 | documented in the medical record.<br>3.To enhance the Care Center infection control program and under the direction of the Director of Nursing or designee, license nurses were in-service on pneumococcal vaccine and the policy indicating residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated will be offered the vaccine within 30 days of admission to the facility unless medically contraindicated.<br>4.Director of Nursing or designee will audit immunization records monthly x 6. Results of the audits will be reported to the QA committee for review and action, as appropriate. The QA committee will determine the need for further audits and/or action plan. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 883 | Continued From page 51 | F 883 | | |

pneumococcal immunization was marked as up to date.

R36's facility Immunization Record date 6/30/21, indicated R36 received the PCV13 vaccine on 6/6/2018 at the age of 69. R36 was overdue for a dose of PPSV23.

During interview on 6/30/21, at 2:06 p.m. registered nurse (RN)-A stated pneumococcal vaccines were offered on admission and reviewed during care conferences and on the Minimum Data Set (MDS). She stated the facility had a master list of residents who needed it and the majority of residents refused. She stated if the vaccine was not documented as given she expected to find a note indicating contraindications or resident refusal.

During interview on 6/30/21, at 3:01 p.m. DON stated she was unsure of the process, and suggested pharmacy would keep track of this.

Records regarding resident education, contraindication, and/or refusal were requested but not provided.

Pneumococcal Vaccine policy dated 07/2019, indicated prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated.

Electronically delivered

July 16, 2021

Administrator
Appleton Area Health
30 S Behl St
Appleton, MN 56208

Re: State Nursing Home Licensing Orders
Event ID: O9ET11

Dear Administrator:

The above facility was surveyed on June 28, 2021 through June 30, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule

number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Kathleen Lucas, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Office: (320) 223-7343 Mobile: (320) 290-1155

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health

Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112  Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 6/28/21-6/30/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed | 2 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 000 | Continued From page 1<br>these orders and identify the date when they will be completed.<br><br>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.<br><br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. | 2 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 000 | Continued From page 2<br>THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | 2 000 | | |
| 2 302 | MN State Statute 144.6503 Alzheimer's disease or related disorder train<br><br>ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING:<br>MN St. Statute 144.6503<br><br>(a) If a nursing facility serves persons with Alzheimer's<br>disease or related disorders, whether in a segregated or general unit, the facility's direct care staff<br>and their supervisors must be trained in dementia care.<br><br>(b) Areas of required training include:<br>(1) an explanation of Alzheimer's disease and related disorders;<br>(2) assistance with activities of daily living;<br>(3) problem solving with challenging behaviors; and<br>(4) communication skills.<br>(c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered.<br>(d) The facility shall document compliance with this section.<br><br>This MN Requirement is not met as evidenced by: | 2 302 | | 8/4/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 302 | Continued From page 3<br><br>Based on interview and document review, the facility failed to ensure the facility's direct care staff and their supervisors received training that included all required components of Alzheimer's/dementia care. This had the potential to affect all 25 residents currently residing in the facility with a diagnosis of Alzheimer's or dementia.<br><br>Findings include:<br><br>During an interview on 6/30/21, at 3:40 p.m. social services (SS)-A stated all staff completed Hand in Hand - Module 1 dementia care training with new employee orientation (NEO) and she provided the training. SS-A further stated staff completed the NetLearning module Providing Age-Appropriate Care to Older Adults annually and "it has a little dementia".<br><br>The Hand in Hand Module 1 information provided indicated the module included an explanation of Alzheimer's disease and related disorders. However, the module did not cover assistance with activities of daily living (ADLs), problem solving with challenging behaviors, and communication skills as required.<br><br>The Providing Age-Appropriate Care to Older Adults information provided indicated the module did not cover assistance with ADLs, problem solving with challenging behaviors, and communication skills as required.<br><br>During an interview on 6/30/21, at 4:47 p.m. SS-A acknowledged Hand in Hand training provided to all staff did not cover all required areas.<br><br>Registered nurse (RN)-A hired 5/28/20, education record lacked evidence the required dementia | 2 302 | Corrected. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 302 | Continued From page 4<br>care training was received.<br><br>RN-B hired 11/28/17, education record lacked evidence the required dementia care training was received.<br><br>Nursing assistant (NA)-E hired 2/26/21, education record lacked evidence the required dementia care training was received.<br><br>NA-H hired 6/18/19, education record lacked evidence the required dementia care training was received.<br><br>NA-I hired 3/12/18, education record lacked evidence the required dementia care training was received.<br><br>Licensed practical nurse (LPN)-B hired 2/6/13, education record lacked evidence the required dementia care training was received.<br><br>Assistant director of nursing (ADON) hired 9/11/18, education record lacked evidence the required dementia care training was received.<br><br>The In-Service Training Program, Nurse Aide policy approved 6/2020, indicated annual in-services would include "training that addressed the care of residents with cognitive impairment; and include training in dementia management". However, the policy did not address NEO dementia care training.<br><br>SUGGESTED METHODS OF CORRECTION: The administrator or designee could develop, review, and /or revise policies and procedures to ensure all direct care staff and their supervisors receive training on required areas of Alzheimer's/dementia care. The administrator or | 2 302 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 302 | Continued From page 5<br>designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 302 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to establish adequate protective measures and supervision to ensure residents who were dependent on oxygen did not smoke while using portable oxygen for 1 of 4 residents (R23) who were listed as smokers in the facility. The deficiency was issued at Immediate Jeopardy (IJ) level as R23 remained at risk for significant injury or death related to smoking while oxygen was in use. The facility failed to follow orders for monitoring weights for 4 of 4 residents (R3, R24, and R25), the facility | 2 830 | Corrected. | 8/4/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 6 | 2 830 | | |

failed to assess bruising for 1 of 1 residents (R13). In addition, the facility failed to notify provider for 1 of 1 residents (R41) for a blood sugar readings above a specified range.

The IJ began on 6/29/21, at 10:49 a.m. when R23 was observed smoking a cigarette in the designated smoking area while using a portable oxygen concentrator via nasal cannula and the oxygen was observed to be turned on. Smoking cigarettes in conjunction with using oxygen can rapidly accelerate combustion. This could result in significant injury or death to the residents, staff, and visitors in the area. The Administrator and Director of Nursing (DON) were notified of the immediate jeopardy at 1:36 p.m. on 6/29/21. The immediate jeopardy was removed on 6/30/21, at 1:38 p.m. but non-compliance remained at an isolated scope and severity which indicated no actual harm with potential for more than minimal harm (Level D).

Findings include:

R23's quarterly Minimum Data Set (MDS) dated 4/28/21, included R23 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating R23 was cognitively intact. R23 required extensive assistance with activities of daily living, locomotion via wheelchair, and was dependent on oxygen. The quarterly MDS lacked documentation of R23's tobacco status. R23's face sheet identified diagnoses included respiratory failure, heart failure, and chronic obstructive pulmonary disease.

R23's care plan revised 2/15/21, reported R23 had limited physical mobility, used a wheelchair, and was dependent on staff for mobility/wheeling to and from all destinations. R23 required use of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 7<br><br>continuous oxygen (O2) and became short of breath with exertion, even when talking. The care plan indicated R23 was able to make needs known. The smoking focus area of the care plan indicated R23 smoked three to four times per day and was O2 dependent. A goal revised 2/12/20, listed R23 would smoke without supervision or injury, follow guidelines, and smoke in designated areas. Interventions revised 2/11/21, included staff were to assist R23 to smoking location, ensure O2 was turned off, and remove the nasal cannula prior to R23 lighting a cigarette. Upon returning to resident, staff were to immediately apply nasal cannula and turn the O2 concentrator on. The care plan identified R23 could light and extinguish her own cigarettes, and keep lighter and cigarettes on self.<br><br>R23's Smoking Safety Screen assessment dated 4/28/21, at 3:20 p.m. indicated R23 had no cognitive loss, visual deficits, or dexterity problems. The assessment indicated R23 was capable of lighting her own cigarette, required assistance getting to and from the smoking area, and did not need the facility to store her lighter and cigarettes. A note on the assessment read, "IDT [interdisciplinary team] feel the resident is A/O [alert and oriented], cognitively intact. Able to light cigarette on own. Can control ashes from cigarette. Understands location where smoking is allowed. Needs assistance to get to/from designated smoking area. Understands O2 must be off when smoking." Conditions also included in the assessment read, "Will request to smoke. Staff will escort the resident to the smoking area. Turn off oxygen. Will use Walkie Talkie or phone to alert staff when would like to come in. Staff will turn O2 back on. Staff escort back into building. Has compact O2 able to apply per self, aware of not to use when smoking." | 2 830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 8<br><br>R23's electronic health record contained a provider orders dated 8/27/20, for O2 up to 5 liters per minute, per nasal cannula via concentration, and to keep O2 saturation between 88 and 94%.<br><br>During observation on 6/28/21, at 5:57 p.m. R23 was in her room, sitting in wheelchair. No burn holes or heat damage were noted on her clothing.<br><br>When interviewed on 6/28/21, at 5:58 p.m. R23 stated she smoked at least once per day, but occasionally went out to the smoking area just to sit while using oxygen. R23 stated she took her portable O2 concentrator with her, turned it off when she smoked, and turned it back on after she put out her cigarette. She stated she kept her cigarettes and lighter with her, but relied on staff to transport her to the smoking area as she was unable to move her wheelchair independently.<br><br>During interview on 6/29/21, at 9:44 a.m. certified nursing assistant (NA)-F stated anyone who smoked was assessed to make sure they were safe. She stated R23 needed help to get to the designated smoking area but could smoke independently. NA-F stated the O2 concentrator was powered on until R23 arrived at the smoking area. Once there, staff turned off the O2, removed the nasal cannula, and hung the tubing on the back of the resident's wheel chair. She stated residents were given a 'walkie' and called for staff assistance when they wanted to leave the smoking area.<br><br>During observation 6/29/21, at 10:28 a.m. R23 was smoking in the designated smoking area with a nasal cannula in her nose. R23's oxygen concentrator was off and placed on a chair to the | 2 830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 9 | 2 830 | | |

resident's left side. R23 had a lit cigarette in her right hand. R23 placed her cigarette in the cigarette receptacle with her right hand and immediately turned on the oxygen concentrator with her left hand. R23 remained in the designated smoking area with another resident who was smoking within six feet of R23 and the oxygen concentrator. There was one other resident and a visitor also present, neither were smoking.

During a subsequent observation on 6/29/21, at 10:49 a.m. director of nursing (DON) and registered nurse (RN)-B were brought to the smoking area. R23 had a lit cigarette in her right hand. Her oxygen concentrator was turned on as indicated by the digital display on the unit. The oxygen tubing was connected to the unit and the cannula was in R23's nose. Another resident sat approximately 5 feet from R23 with a lit cigarette. The two residents were facing each other. DON confirmed the concentrator was turned on and immediately turned it off. DON provided immediate education to R23 regarding smoking when wearing O2 was a safety hazard. DON requested R23 remove the nasal cannula, however R23 refused. DON requested all smoking materials from R23 but R23 refused. R23 stated she was not previously told to remove her nasal cannula when smoking. R23 then placed her cigarette in the receptacle, refused DON's offer to transport her into the facility, and called for alternate assistance to go back into to the building. R23 remained supervised by DON and RN-B until 10:53 a.m. when NA-G arrived. NA-G returned R23 to her room at 10:57 a.m.

When interviewed on 6/29/21, at 10:53 a.m. DON stated wearing O2 while smoking was unacceptable. Her expectation was residents

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 10 | 2 830 | | |

removed the nasal cannula prior to smoking. She stated her preference was oxygen was not brought to the smoking area at all. DON confirmed R23 was re-educated immediately regarding the dangers of smoking with O2. R23 agreed to remove the O2 cannula when going out to smoke, but still requested the oxygen concentrator remain with her when she went to smoke. DON stated R23 needed to be reassessed with new interventions placed for safety.

R23's progress note dated 6/29/21, at 11:18 a.m. identified, "Reported by staff that resident was outside in the designated smoking area visiting with surveyor and she lit a cigarette while she had oxygen on. Resident interviewed in her room and she was tearful stating she had finished her cigarette and turned her oxygen on while still outside visiting. She states she forgot the oxygen was on and lit a cigarette and didn't realize until she had taken two puffs. Reviewed smoking policy with resident and another nurse present. Explained to resident that plan would now change and she would have supervision with smoking and that smoking supplies would be kept at the nurse's desk. Oxygen concentrator and tubing would not be taken outside to smoking area. Resident became upset, raising voice at nurse stating,'What kind of prison is this!' 'You can't take my cigarettes from me!' Risk for injury, burns, explosion, and possible death explained to her as it has been done in the past. Resident crying and telling staff that they are abusing her. Resident did calm down with 1:1 and gave nurse her lighter and four cigarettes. Stated she did not have anymore in her room. Staff updated on new smoking plan, resident will be supervised with smoking, concentrator and tubing will be left in her room."

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 11<br><br>The facility Smoking Policy last revised 7/18 with expiration of 7/19 outlined expectations for patients, tenants, visitors, and employees. The policy identified the designated smoking areas for visitors and long term care (LTC) center residents were in the LTC center parking lot on the west side near the kitchen entrance, and on the South end of the west parking lot near the street or dumpster, and on the west end of the parking lot under the shade tree. The policy lacked direction for safe smoking assessment, and further lacked any requirement to remove oxygen prior to smoking. No additional policies or procedures related to smoking safety or unsupervised smoking were provided.<br><br>The Smoking Safety Screen dated 6/29/21, at 11:47 a.m. identified R23 was reassessed safe to smoke with supervision and one-to-one assistance. The facility would store R23's lighter and cigarettes.<br><br>During continuous observation on 6/30/21, at 12:52 p.m. R23 put on her call light. NA-K entered R23's room, removed R23's nasal cannula and concentrator from her wheelchair then pushed R23 to the nursing station. NA-K checked R23's oxygen saturation level, retrieved a bag containing R23's smoking supplies from the medication room, and gave it to R23. NA-K transported R23 to the designated smoking area where R23 smoked a cigarette accompanied by NA-K.<br>-At 1:03 p.m. NA-K was replaced by NA-F.<br>-At 1:12 p.m. R23 placed her cigarette in the receptacle and requested to return to her room. NA-F transported R23 to the nursing station, checked R23's O2 saturation level, placed the bag with R23's lighter and cigarettes in the | 2 830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 12<br>medication room, and returned R23 to her room where NA-F placed the nasal cannula on R23 and turned on the oxygen. R23 was never left without staff supervision.<br><br>The immediate jeopardy that began on 6/29/21, was removed on 6/30/21, at 1:38 p.m. when it was verified, based on observation and interview that the facility successfully implemented a removal plan which included the following:<br><br>Staff were educated regarding:<br>-The change in R23's smoking supervision requirement<br>-Removal of R23's nasal cannula and oxygen concentrator prior to transportation to the designated smoking area<br>-Facility storage of R23's cigarettes and lighter<br>-Monitoring R23's O2 saturation levels both before and after smoking<br>-All cigarettes and lighters were removed from R23's possession. R23 was re-educated regarding the risk of smoking with oxygen, and care plan was updated to reflect oxygen and nasal cannula will remain in R23's room while smoking.<br>-All residents who smoked, including R23, were re-assessed for safe smoking.<br><br>The facility smoking policy was reviewed for adequacy and updated to include LTC residents will have a smoking assessment on admission, initiation of smoking after admission, quarterly, and any changes of condition which include functionality. Education on smoking cessation should be addressed with each assessment and documented. Smoking materials and any other source of ignition should be kept at least 15 feet (4.3 meters) away from an oxygen-enriched atmosphere such as a resident receiving oxygen | 2 830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 13 | 2 830 | | |

via nasal cannula, oxygen mask or other delivery device. All smoking materials will be stored in the medication room for residents who require oxygen. Oxygen, nasal cannula and mask will remain in the resident's room while smoking in the designated smoking area. Residents who require supervision will be accompanied by staff to the smoking area and remain with the resident for the duration of the smoke break. Residents without the dexterity to hold a cigarette will be prohibited from smoking. The need for supervision or independent will be reflected in the smoking assessment, addressed in the care plan, and updated when indicated. The care center reserves the right to prohibit smoking when there is imminent threat to patient safety.

R25's face sheet undated, indicated diagnosis included acute on chronic diastolic (congestive) heart failure, adjustment disorder with depressed mood, major depressive disorder, chronic obstructive pulmonary disease, and anxiety disorder.

R25's quarterly minimum data set (MDS) dated 5/4/21, indicated moderate cognitive impairment. R25's MDS further indicated need for assistance of one assist for dressing and personal hygiene.

R25's care plan revised on 6/15/21, indicated the resident has an activity of daily living (ADL) self-care performance deficit r/t chronic diastolic CHF, hx of bilateral pleural effusion, and moderate cognitive deficit. R25's care plan further indicated the resident has congestive heart failure and vital signs should be monitored weekly.

R25's weight calculations percentage loss on 05/19/2021, the resident weighed 204.6 lbs. On

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 14<br>06/16/2021, the resident weighed 193.3 pounds which is a -5.52 % Loss.<br><br>R25's cardiology note dated 6/4/21, clinical impression included: marked edema with evidence of pulmonary vascular congestion (extra fluid in the lungs), I believe this patient would benefit from increased diuretics, chronic heart failure. Recommendation included changing amlodipine to 10 mg as amlodipine is likely to make his peripheral edema worse. Start zaroxolyn 2.5 mg by mouth every other day in the morning with his Lasix to see if we can reduce his pulmonary congestion and peripheral edema.<br><br>R25's provider orders dated 6/19/21 Lasix (diuretic) 80 mg by mouth every morning for CHF and 40 mg by mouth every evening for CHF.<br><br>Progress note dated 6/23/21, at 11:20 am indicated new order to obtain weights three times per week, one time a day every Monday, Wednesday, and Friday for weight loss and resident is on isolation precautions for C-diff.<br><br>Staff care guide sheets updated 6/29/21, indicated R25 should be weighed on Wednesdays.<br><br>R25's weight list dated 7/1/21, indicated last weight done on 6/16/21 was 193.2. The only other documentation of weight was 5/19/21 which was 209.4 (was in a wheelchair), and 5/17/21 weight was 204.6.<br><br>During interview on 6/29/21, at 12:59 p.m. trained medication aide (TMA)-A indicated resident is to be monitored for weights due to weight loss and his current infection of c-diff. TMA stated the nursing assistants (NA) weigh the residents and | 2 830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 15 | 2 830 | | |

mark them on the clipboard the nurses will review and enter into the computer. TMA further stated it was important to weigh residents to make sure they are stable and not losing or gaining to much weight.

During interview on 6/29/21, at 1:15 p.m. licensed practical nurse (LPN)-A stated R25 has a diagnosis of c-diff and staff are monitoring his weights due to weight loss. LPN-A stated right now they have no way of weighing him outside of his room due to being on precautions, however he thinks they could use the hoyer lift and just clean the machine, but has not brought this to the attention of the registered nurses. LPN-A confirmed R25 should be being weighed three times a week Monday, Wednesday and Friday, and stated "It was a nursing order not a provider order". LPN-A stated he was not aware of any weight loss with R25 until he looked into the computer while talking and stated he would classify his weight loss as a significant loss. LPN-A further stated the provider and dietician should be notified as well to further monitor.

During interview on 6/29/21, at 2:15 p.m. NA-B stated R25 should be weighed on his bath days which was Wednesday and then reported to the nurse if he refused. NA-B stated it was important to weigh residents to make sure their weights are stable.

During interview on 6/29/21, at 4:14 p.m. Dietician stated R25 was put on strong diuretics and now has c-diff and it was important to monitor his weights to make sure he has not lost any more weight. The dietician stated she sees his weight was up to 204, but he is now back to baseline at 193 and stated they should be monitoring his weight to make sure he is not losing anymore

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 16<br>weight. The Dietician stated she sees an order that was put in by nursing on 6/18/21 for three times a week weights and would expect staff to be weighting him.<br><br>During interview on 6/29/21, at 4:51 p.m. registered nurse (RN)-A stated in general all residents should be weighed at least weekly, however with R25 there was an order that was just put in for three times a week weights. RN-A stated she would be expecting staff to weigh residents and if they were unable to weigh him that it should be reported to the RN's. RN-A stated it was important to monitor R25's weight as he was on diuretics and due to his nutritional status and c-diff.<br><br>During interview on 6/29/21, at 5:05 p.m. RN-B stated R25 should be monitored for weight three times a week and if no specific order all residents should be done once a week. RN-B further stated it is not ok to go a month without being weighed and it is important to monitor his weights due to being on diuretics and c-diff and should monitor for a decline in status.<br><br>During interview on 6/30/21, at 10:35 a.m. the director of nursing (DON) stated if a resident has a weight that states three times a week weights, she would expect this resident to be weighed three times a week. DON stated she was not aware that he was not being weighed or had no way of weighing R25 due to precautions. DON stated there are ways to weigh someone on precautions if that meant getting a new mobile scale or bringing resident out when no other residents were in the hallway to keep isolation precautions. DON stated it was important to weigh R25 to monitor his status and make sure he is not losing to much weight or regaining | 2 830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 17<br>weight with the diuretics.<br><br>Weight assessment and intervention policy expires 6/21, "The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. Weights will be recorded in each unit's weight record chart or notebook and in the individual's medical record. Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified nursing will immediately notify the dietitian in writing. Verbal notification be confirmed in writing".<br><br>R41's Face sheet undated, indicated diagnosis: diabetes type 2 with diabetic polyneuropathy, diabetes mellitus with diabetic chronic kidney disease, and essential hypertension.<br><br>R41's quarterly MDS dated 6/3/21, identified no cognitive impairment.<br><br>R41's provider orders dated 6/29/21, indicated Novolog FlexPen Solution Pen-injector 100 UNIT/ML (Insulin Aspart) (medication to bring down blood sugar) Inject as per sliding scale: if 0 - 149 = 0; 150 - 200 = 2; 201 - 250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351 - 999 = 10 to Notify MD, subcutaneously before meals and at bedtime related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS (E11.9).<br><br>R41's weights and vital summary dated 6/29/21, indicated blood sugar on 6/28/21 at 12:01 was 442 and then on 6/15/21 at 10:51 pm blood sugar was 411.<br><br>During interview on 6/29/21, at 1:05 p.m. LPN-A | 2 830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 18<br><br>stated he was aware of R41's blood sugar was 442 on 6/28/21, but stated "I knew it was from R41 eating ice cream and sometimes you have to use your common sense and I did not notify the provider". LPN-A stated you should follow the provider orders however with him it is due to R41's bad habits. LPN-A further stated the providers have access to his point click care and can see his results. LPN-A stated he went down and assessed R41 and he wasn't having symptoms so he gave him his insulin but did not follow the order and notify the provider. LPN-A stated he could not find documentation on 6/28/21 nor 6/15/21 when blood sugars where elevated.<br><br>During interview on 6/29/21, at 4:22 p.m. the Dietician reviewed Novolog orders and stated if residents blood sugar was 442 according to providers orders the provider should of been notified and is unacceptable for staff not to notify the provider. The dietician further stated it is important to notify provider of high blood sugars as it could mean their medications need to be adjusted or there is something else going on with the resident.<br><br>During interview on 6/29/21, at 5:12 registered nurse (RN)-B stated if a residents blood sugar was 442 she would expect staff to notify the provider and it was unacceptable for the nurse not to notify the provider even if the resident ate ice cream. RN-B stated it was important to follow providers orders.<br><br>During interview on 6/30/21, at 10:35 a.m. the director of nursing (DON) stated according to R41's Novolog orders any blood sugar over 351 the nurse should be giving him 10 units of insulin and calling the provider. DON stated it is nursing | 2 830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 19 | 2 830 | | |

standards to follow provider orders and notify the provider if the order states to or the blood sugar is out of the normal despite R41 having ice cream. DON further stated it was important to notify the provider in case the provider needed to adjust his medication. DON further stated she will be changing the settings for his orders/parameter in point click care as it has the capability to make sure an outcome was completed.

Diabetes-Clinical protocol expires 6/21, indicated " The physician will follow up on any acute episodes associated with a significant sustained change in blood sugars or significant deterioration of previous glucose control and document resident status at subsequent visits until the acute situation is resolved. The physician will order desired parameters for monitoring and reporting information related to blood sugar management. The staff will incorporate such parameters into the medication administration record and care plan. The staff will identify and report issues that may affect, or be affected by a patient's diabetes and diabetes management such as foot infection, skin ulceration, increased thirst, or hypoglycemia. ".

Nursing care of resident with diabetes mellitus expires 6/21, indicated "The management of individuals with diabetes mellitus should follow relevant protocols and guidelines. The physician will order the frequency of glucose monitoring".

R13's quarterly MDS dated 4/6/21, indicated R13 was severely cognitively impaired, she was sometimes able to make herself understood and sometimes able to understand others. R13's diagnoses included dementia, diabetes, anxiety, hypertension and heart failure. R13 was able to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 20<br>move her upper extremities without limitations.<br><br>During observation on 6/28/21, at 12:05 p.m. R13 was noted to have a large bruise on her left arm that started at her wrist and extended to approximately halfway between her wrist and her elbow. The bruise also wrapped around her arm. The bruise was at various stages of healing. Also noted was a large, deep purple bruise starting at the base of her left thumb and extended to the back of her hand. R13 had several smaller, scattered, deep purple bruises on her right arm. R13 was not able to explain how she got the bruises.<br><br>Progress notes failed to identify the bruising.<br><br>There were no skin assessments completed during 6/2021.<br><br>On 6/29/21, at 12:48 p.m. nursing assistant (NA)-A confirmed the bruising on both R13's arms and stated she had previously noted the bruising but was not sure how long they had been there. NA-A explained what she reports to the nurse, when doing daily skin checks, depends on what it is. If it is something that is common for that resident, such as the bruising is for R13, she would first talk with her co-worker, another nursing assistant, to decide if it needs to be reported. NA-A did not recognize the bruising on R13's arms. NA-A was not sure if she would have reported this, indicating she would talk with another nursing assistant first. NA-A stated R13 does not become physically aggressive or resistive with cares but does swing her arms around when she gets excited and is happy.<br><br>On 6/29/21, at 1:45 p.m. licensed practical nurse (LPN)-A confirmed he was aware of the bruising | 2 830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 21<br>on R13' arms but was not aware of how they happened. LPN-A confirmed they were not monitoring the bruising or documenting in the progress notes.<br><br>On 6/29/21, at 2:09 p.m. LPN-B confirmed the bruises located on R13's arms. She stated, R13 is given her call light, but does not consistently use it. She would often slap her arms to get the staff attention. LPN-B indicated she had made previously made notes regarding R13's bruising and discussions with R13's daughter about the bruising. LPN-B's notes were requested but were not received.<br><br>On 6/29/21, at 2:17 p.m. registered nurse (RN)-B stated she expected all skin concerns or changes, including bruising, were reported to the nurse and documented. This included previously reported skin concerns. Reported bruises should be documented in the progress notes with size and appearance. Bruising should then be monitored either daily or weekly, depending on the severity of it. Bruises are investigated to decide the cause and how to avoid recurrence. RN-B indicated she was not aware of R13's bruises on her arms, but confirmed size, location and varied stages of healing.<br><br>On 6/30/21, at 1:50 p.m. director of nursing (DON) stated anything that was seen, new or existing, needed to be documented, even if it is a bruise that is fading. DON expected bruising with a known cause is still investigated and documented. If a resident bruises easily, then need to determine the cause so changes can be made to prevent bruising.<br><br>A facility policy regarding skin checks was requested but was not received. | 2 830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 22<br><br>R3's face sheet undated, indicated diagnoses included morbid obesity with alveolar hypoventilation (slow/shallow breathing), localized edema, unspecified diastolic (congestive) heart failure, pulmonary hypertension, type 2 diabetes mellitus with diabetic neuropathy, schizophrenia, borderline personality disorder, and anxiety disorder.<br><br>R3's quarterly minimum data set (MDS) dated 3/11/21, indicated cognition intact. R3's MDS further indicated need for extensive assist of one for bed mobility, transfers, ambulation, dressing, toilet use, and personal hygiene.<br><br>R3's care plan revised on 3/27/19, indicated resident on diuretic therapy and hypertension (HTN) medications r/t edema, HTN, chronic kidney disease (CKD) and poor circulation. R3's care plan further indicated resident monitored for side effects and effectiveness, wt. (weight) and vital signs (VS) at least weekly or per order and prn (as needed), and MD updated of excessive wt. gain or abnormal VS from resident's baseline.<br><br>R3's signed provider order summary dated 5/13/21, indicated weight one time a day every Monday, Wednesday, Friday related to localized edema.<br><br>R3's signed provider order summary dated 5/13/21, indicated metolazone (diuretic) 2.5 mg by mouth one time a day every Mon, Wed, Fri related to localized edema was initiated 11/13/17. Additionally, provider order dated 1/24/20, bumetanide (diuretic) 1 mg by mouth two times a day related to unspecified diastolic (congestive) heart failure. | 2 830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 23<br><br>R3's weight summary dated 7/1/21, indicated documented weights from the last six months were obtained 1/8/21, 1/19/21, 1/22/21, 1/29/21, 2/2/21, 2/5/21, 2/9/21, 2/16/21, 2/23/21, 3/2/21, 3/5/21, 3/9/21, 3/12/21, 3/16/21, 3/23/21, 3/26/21, 3/31/21, 4/8/21, 4/9/21, 4/13/21, 4/20/21, 4/27/21, 5/4/21, 5/5/21, 5/7/21, 5/11/21, 5/18,21, 5/25/21, 6/1/21, 6/8/21, 6/15/21, and 6/29/21.<br><br>During interview on 6/30/21, at 9:29 a.m. licensed practical nurse (LPN)-B stated that R3 had her weight taken on Tuesdays. As LPN-B reviewed R3's electronic health record (EHR), LPN-B stated "I see the order now for Monday, Wednesday, Friday. It needs to be adjusted." LPN-B further stated R3 wanted to be weighed only one time a week and the management of weights was "overall a team effort".<br><br>During interview on 6/30/21, at 11:13 a.m. registered nurse care manager (RN)-A stated the charge nurse monitored weights. RN-A further stated the charge nurse reviewed resident orders prior to provider visits to ensure order changes were requested, and weights were reviewed at standup meetings. RN-A further stated if provider orders were not followed, it would be "written up",<br><br>During interview on 6/30/21, at 2:51 p.m. interim director of nursing (DON) stated staff were expected to follow provider orders for weights and nurses were expected to monitor weights. The DON further stated if a resident refused to be weighed, she would expect the nurse to completed an assessment and notified the provider after the resident's third refusal. Additionally, the DON stated she expected orders to be followed as written until they were discontinued or changed. | 2 830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 24<br><br>R24's quarterly MDS dated 4/29/21, indicated R24 was cognitively intact, used a walker or wheelchair for locomotion, and required limited assistance/supervision with walking and toileting. The MDS identified diagnoses which included congestive heart failure, high blood pressure, kidney failure, and dementia.<br><br>R24's care plan dated 2/14/21, included an intervention to weigh R24 as ordered by provider which was to be completed at the same time under the same conditions with same amount of clothing.<br><br>R24's order summary report contained a provider order for daily weights relating to diagnosis of congestive heart failure with a start date of 1/26/21, and no end date.<br><br>R24's treatment administration record (TAR) lacked documentation of daily weights on 30 of 104 days between 2/15/21, and 6/28/21. No explanation of missing values were recorded on R24's progress notes.<br><br>During interview on 6/30/21, at 2:51 p.m. DON stated she expected provider orders to have been followed. She stated if the TAR noted a task was complete she expected it to have been completed otherwise it would be considered falsification.<br><br>DON reviewed R24's daily weight documentation and stated she observed gaps. She reviewed the TAR and acknowledged there were more weights documented as having been completed than were recorded in R24's vital sign documentation. She stated they [staff] signed off something that was not completed, and her expectation was weights would be recorded and signed off only when completed. | 2 830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 25<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could develop policy and educate responsible staff regarding the following: policy and procedure to keep resident who smoke and use oxygen safe, conducting weights according to physician's orders, monitoring of bruising, and reporting of blood glucose per physician orders. The DON or designee could conduct audits of responsible staff to ensure daily weights are completed according to physician orders, to ensure physician is notified as orders dictate, to ensure there is documentation that bruises are being monitored and ensure procedures are followed including appropriate supervision of residents who smoke. This information could be brought to the QAPI team for review.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 2 830 | | |
| 2 920 | MN Rule 4658.0525 Subp. 6 B Rehab - ADLs<br><br>Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that:<br>B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document | 2 920 | Corrected. | 8/4/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 920 | Continued From page 26<br>review, the facility failed to ensure shaving was offered or provided for 2 of 3 residents (R25 and R27) in the sample who were dependent upon staff for assistance with activities of daily living (ADLs).<br><br>Findings include:<br><br>R25's face sheet undated, indicated diagnosis included acute on chronic diastolic (congestive) heart failure, adjustment disorder with depressed mood, major depressive disorder, chronic obstructive pulmonary disease, and anxiety disorder.<br><br>R25's quarterly minimum data set (MDS) dated 5/4/21, indicated moderate cognitive impairment. R25's MDS further indicated need for assistance of one assist for dressing and personal hygiene.<br><br>R25's care plan revised on 6/15/21, indicated the resident has an ADL self-care performance deficit r/t chronic diastolic CHF, hx of bilateral pleural effusion, moderate cognitive deficit. Paroxysmal atrial fibrillation hypertension, 3rd degree av block with pacemaker, hypothyroidism, anxiety and history of depression with interventions listed as the resident preferred dressing/grooming routine is done before breakfast. Personal hygiene: the resident prefers shave every morning. Able to shave on own after set up. Touch up as needed. Clean shaver for the resident.<br><br>During observation and interview on 6/28/21, at 12:42 p.m. R25 was sitting in recliner and had approximately 1/4 inch facial hair covering cheeks, chin, neck, and below nose. Hair appears to be coarse gray/white. R25 stated that they are going to help him with shaving today. | 2 920 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 920 | Continued From page 27<br><br>During observation on 06/28/21, 7:28 p.m. R25 sitting in his recliner and continued to be unshaven, hair remain approximately 1/4 in. long on face and chin which was, coarse gray/white hair.<br><br>During observation and interview on 06/29/21, at 10:02 a.m. R25 was sitting in recliner, remained unshaven with approximately 1/4 in coarse gray and white hair on face, chin and neck. R25 stated "I would like to be shaved some time today".<br><br>During interview on 6/29/21, at 12:59 p.m. trained medication aide (TMA)-A stated that R25 is assistance of one for all cares including bathing, dressing, and shaving.<br><br>During interview on 6/29/21, at 1:15 p.m. licensed practical nurse (LPN)-A stated R25 does require assistance with cares. LPN-A further stated that R25 can shave himself if someone sets him up to do so. LPN-A stated it is important for men to be shaved if that is their preference as it helps with self esteem and everyone wants to look their best.<br><br>During interview on 6/29/21, at 2:15 p.m. nursing assistant (NA)-B stated she had just finished getting R25 cloths changed and was in the process of cleaning up the room. NA-B stated that it was important to shave all men who wanted to be shaved and this would be indicated on the residents care plan. NA-B further stated she had not shaved R25 as she usually does not help with residents getting up in the morning. NA-B further stated she wasn't sure if he was or wasn't shaved yet today. NA-B stated being shaved can help the individual feel better. NA-B stated she can go back into room and assist R25 | 2 920 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 920 | Continued From page 28 | 2 920 | | |

with shaving. NA-B stated if you give him the razor he will usually shave himself and if he refused the nurse should be notified and it should be documented. NA-B went back into R25's room.

During interview on 6/30/21, at 9:37 a.m. NA-C stated that all men should be shaved daily for appearance, if they choose.

R27's Face sheet undated, indicated diagnosis: unspecified dementia with behavioral disturbance, delirium due to known physiological condition, and anxiety.

R27's quarterly MDS dated 5/5/21, indicated moderate cognitive impairment. MDS further indicated R27 requires assistance of one for dressing and personal hygiene which included combing hair, brushing teeth, and shaving.

R27's care plan revised on 11/17/20, indicated the resident has an ADL self-care performance deficit with interventions: the resident prefers dressing/grooming routine is done prior to breakfast.

During observation and interview on 6/29/21, at 12:56 p.m. R27 had approximately 1/4 inch coarse gray/white hair on cheeks, chin, neck, and below nose. R27 stated he wants to be shaved as he likes to have his hair short. R27 was not sure the last time he was shaved.

During observation on 6/29/21, at 9:28 a.m. R27 walking in the hallway with front wheeled walker. R27 facial hair noted.

During observation on 6/29/21, at 12:16 p.m. R27 walking down hallway continue to have

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 920 | Continued From page 29<br>approximately 1/4 in. coarse gray/white hair on face and neck.<br><br>During interview on 6/29/21, at 1:28 p.m. license practical nurse (LPN)-A stated R27 requires assistance of 1 with all morning and afternoon cares including shaving and oral cares, which staff should be providing to him.<br><br>During interview on 6/29/21, at 2:15 p.m. nursing assistant (NA)-B stated all men should be shaved if that is their preference and should be offered morning and night.<br><br>During interview on 6/29/21, at 5:16 p.m. registered nurse (RN)-B stated R27 can shave himself if you cue him. RN-B also stated it is important to assist with grooming as they can't identify the problem themselves and R27 is a very social man and you want him to have good appearance.<br><br>During observation on 6/30/21, at 7:14 a.m. R27 was walking down hallway with front wheeled walker and continued to have facial hair on face and neck.<br><br>During interview on 6/30/21, at 8:43 a.m. NA-C stated R27 has dementia and needs assistance with shaving. NA-C further stated she had attempted to shave him this morning but his razor was full of hair and needed to find a brush to clean it. NA-C stated all men, if they prefer it, should be shaved daily for appearance and R27 is a social man and it is important to him to have good appearance. NA-C further stated it appeared R27 has not been shaved for many days which is not ok as he likes his hair short.<br><br>During interview on 6/30/21, at 10:35 a.m. the | 2 920 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 920 | Continued From page 30<br>director of nursing (DON) stated that both men and women should be shaved if they have hair growing and they prefer it to be shaved. DON further stated it is not acceptable for men to not be shaved. DON stated not being shaved can be a dignity issue along with harbor germs as food can get caught in the hair.<br><br>Shaving the resident policy revised 10/2010, indicated "The purpose of this procedure is to promote cleanliness and to provide skin care. Notify the supervisor if the resident refuses the procedure".<br><br>Activities of Daily Living policy expires 6/21, indicated "residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene".<br><br>Care plan-Comprehensive person-centered policy expires 6/21, indicated "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident".<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 920 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21015 | Continued From page 31 | 21015 | | |
| 21015 | MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi<br><br>Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review the facility failed to make sure the fans in the kitchen were properly cleaned and free of dust which had the potential to affect all 43 residents in the facility.<br><br>Findings include:<br><br>During observation on 6/28/21, at 10:29 a.m. thick dust/debris was observed on black oscillating fan that was blowing towards the steam table and prep counters.<br><br>During interview on 6/28/21, at 10:29 a.m. cook-A stated it was not sanitary to have dust on fan, she is not sure who cleans it.<br><br>During interview on 6/28/21, at 10:52 a.m. staffing rep (assisting with dietary) observed the fan and stated that she sees a lot of lint/debris on the fan and further stated it was not ok for that fan to be blowing in the kitchen as it is a fire hazard and not sanitary to be blowing the dust onto the serving areas. Staffing rep stated she was unsure who cleans the fan as she is not sure the facility provided the fan or if it was a staff members.<br><br>During interview on 6/29/21, at 4:08 a.m. the | 21015 | Corrected. | 8/4/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21015 | Continued From page 32<br>dietician stated it is not acceptable to have a fan that was caked with dust in the kitchen, as it could contaminate the food sources.<br><br>Infection prevention and control (Dietary) policy revised 9/2016, indicated the purpose "To prevent and control contamination and the spread of infection within the dietary department" "All equipment shall be thoroughly cleaned after each use"<br><br>SUGGESTED METHOD OF CORRECTION:<br>The dietary manager, registered dietician, or administrator, could ensure appropriate infection control technique is maintained in the kitchen. The facility could update or create policies and procedures, and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits periodically to ensure compliance. The facility should report audit findings to Quality Assurance Performance Improvement (QAPI) for further recommendations and to determine compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21015 | | |
| 21620 | MN Rule 4658.1345 Labeling of Drugs<br><br>Drugs used in the nursing home must be labeled in accordance with part 6800.6300.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document | 21620 | Corrected. | 8/4/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21620 | Continued From page 33 | 21620 | | |

review the facility failed to ensure medications available for use in a medication cart were appropriately labeled with an opened date in 2 of 2 medication carts reviewed for medication storage.

Findings include:

R40's face sheet dated 6/30/21, indicated R40's diagnosis included dementia and glaucoma.

R40's medication administration record (MAR) for 6/1/21-6/30/21, indicated R40 received scheduled eye drop, Azopt Suspension 1% to both eyes two times daily for glaucoma.

On 6/29/21 at 4:35 p.m., licensed practical nurse (LPN)-A and surveyor observed R40's Azopt Suspension 1% were opened, in the cart. There was no opened date on the prescription label or on the medication bottle. According to the pharmacy label, this medication was filled on 5/28/21.

On 6/29/21, during medication cart inspection, LPN-A stated it was expected that an open date is written on the pharmacy label when eye drop bottles are first opened and used. The reason to date the label is because eye drops have an expiration date and are not supposed to be administered after that date. LPN-A was not certain what the expiration date after opening was for Azopt but thought most eye drops were good for 28 days after they were opened. LPN-A confirmed there were no other opened bottles of Azopt solution 1% for R40.

On 6/30/21, at 3:32 p.m. pharmacy consultant (PC)-A indicated eye drops needed to be dated when opened. The risk of bacterial growth

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21620 | Continued From page 34<br>increased the longer the bottle was used after it was opened. There was an increased risk of infection if the eye drop was used after the expiration date. PC-A stated Azopt eye drops should be stopped no more than 28 days after they are opened.<br><br>On 6/30/21, at 2:00 p.m. director of nurse (DON) stated she expected eye drops were labeled when opened. Unlabeled eye drops were unacceptable.<br><br>Facility policy, Labeling of Medication Containers, last revised 7/2019, indicated the medication label should include the expiration date when applicable, but did not address the need to label eye drops with the open date.<br><br>SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures related to labeling eye drops with open date and provide education to staff who pass medications regarding the importance of dating these medications. The DON or designee could do periodic medication cart audits to ensure eye drops are being labeled with an open date.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21620 | | |
| 21805 | MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by | 21805 | | 8/4/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21805 | Continued From page 35<br>employees of or persons providing service in a health care facility.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review the facility failed to ensure 3 of 4 residents (R4, R18, and R40) were provided a dignified dining experience.<br><br>Findings include:<br><br>R4's quarterly minimum data set (MDS) dated 3/24/21, indicated moderate cognitive impairment and was independent with eating.<br><br>R18's quarterly MDS dated 6/2/21, indicated severe cognitive impairment and needed assistance with eating.<br><br>R40's significant change MDS dated 4/19/21, indicated severe cognitive impairment and required supervision with eating.<br><br>During observation on 6/28/21, at 11:57 a.m. unknown dietary aid brought R4 her meal. R40 and R18 were already sitting at table with R4. Other residents in dining room being asked what they want for meals. No one asked R40 or R18 what they wanted to eat.<br><br>During observation on 06/28/21, at 12:05 p.m. R40 reached across table and took a bite of R4's food. R4 stated "that is mine". Other individuals were in the dining room receiving there meals from staff.<br><br>During observation on 6/28/21, at 12:07 R40 received her meal. | 21805 | Corrected. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21805 | Continued From page 36<br><br>During observation on 6/28/21, at 12:11 p.m. 18 received her meal tray. Staff assisting with cutting up food at table at table 1.<br><br>During interview on 6/29/21, at 12:44 p.m. dietary aide (DA)-A stated when passing out trays all individuals at that same table should be delivered their meals at the same time. DA-A stated it is not fair nor acceptable for residents to watch others at the same table eating.<br><br>During interview on 6/29/21, at 12:55 p.m. train medication aide (TMA)-A stated when staff are passing meal trays in the dining room they should be serving everyone at one table first before moving to the next one. TMA-A further stated it was not ok for one resident to get food and the other ones to wait and watch that individual eat.<br><br>During interview on 6/29/21, at 1:30 p.m. licensed practical nurse (LPN)-B stated staff grab a name tag and then find the resident in the dining room and ask them what they would like to eat. LPN-B further stated there is no rhyme or reason to who the staff grab first. LPN-B stated they should be serving everyone at the table before moving on to the next. LPN-B further stated it is not right to have one person served first and then the others having to wait. LPN-B stated if that was me "I would be upset".<br><br>During interview on 6/29/21, at 4:59 p.m. registered nurse (RN)-A stated the dining process has now changed to residents eating in the dining room. RN-A stated they need to work on some of the processes in the dining room. RN-A further indicated it is a dignity issue when you have one resident served their meal and the others at the table just waiting. | 21805 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00655 | A. BUILDING: _____ B. WING _____ | 06/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| APPLETON AREA HEALTH | 30 S BEHL ST APPLETON, MN 56208 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 21805 | Continued From page 37<br><br>During interview on 6/30/21, at 10:35 a.m. the director of nursing (DON) stated all residents should be served one table at a time and it is not ok otherwise. DON further stated "I wouldn't want someone eating in my face while I am waiting".<br><br>Requested policy for dining room procedure: no policy regarding this. Facility did supply policy for assistance with meals expired 6/21.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to ensure residents dignity is being maintained. The facility could update policies and procedures, educate staff on these changes, and audit to ensure resident(s) dignity are maintained. The results of these audits will be reviewed by the quality assurance committee to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21805 | | |

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered

July 26, 2021

Administrator
Appleton Area Health
30 S Behl St
Appleton, MN 56208

RE: CCN: 245231
Cycle Start Date: July 13, 2021

Dear Administrator:

**Please Note: The health and life safety code survey findings have been processed under separate enforcement cycles. This letter addresses only the Life Safety Code.**

On July 13, 2021, a survey was completed at your facility by the Minnesota Department 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.

We are pleased to inform you that this survey resulted in no deficiencies being issued.

The CMS-2567 is being electronically delivered.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **07/13/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **APPLETON AREA HEALTH** | **30 S BEHL ST**<br>**APPLETON, MN 56208** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Appleton Municipal Nursing Home was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and NFPA 99 (2012 edition) Health Care Facilities Code.<br><br>Appleton Municipal Nursing Home is a 2-story building with a no basement. The building was constructed at 3 different times. The original building was constructed in 1964 and was determined to be of Type II(000) construction. In 1976, an addition was added to the east that was determined to be of Type II(222). In 1992 an addition was added to the southeast that was determined to be of Type II(000) construction. Because the original building and the additions meet the construction type allowed for a Type II (000) existing building, the facility was surveyed as one building.<br><br>The building is fully sprinklered throughout. the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.<br><br>The facility has a capacity of 50 beds and had a census of 43 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is | K 000 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245231 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **07/13/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **APPLETON AREA HEALTH** | **30 S BEHL ST**<br>**APPLETON, MN 56208** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | Continued From page 1<br>MET. | K 000 | | |