DEPARTMENT OF HEAI	TH AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: O9ET
	PART I -	TO BE COMPI	LETED BY 1	THE STAT	TE SURVEY AGENCY	Facility ID: 00655
1. MEDICARE/MEDICAID PROV	IDER NO.	3. NAME AND AD (L3) APPLETON				4. TYPE OF ACTION: <u>7</u> (L8)
(L1) <b>245231</b> 2.STATE VENDOR OR MEDICAI	D NO	(L4) 30 S BEHL S				1. Initial 2. Recertification
(L2) <b>705040200</b>	DINO.	(L5) APPLETON			(L6) <b>56208</b>	3. Termination     4. CHOW       5. Validation     6. Complaint
						7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE (	OF OWNERSHIP	7. PROVIDER/SU			<u>02</u> (L7)	8. Full Survey After Complaint
(L9)	110 10001 (T. D. I)	01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	
	/12/2021 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID		09/30
0 Unaccredited 1 TJC 2 AOA 3 Othe		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	0,50
11LTC PERIOD OF CERTIFICAT	ION	10.THE FACILITY	' IS CERTIFIED	AS:		
From (a):		X A. In Complia	nce With		And/Or Approved Waivers Of	0
To (b):			equirements		2. Technical Personnel	6. Scope of Services Limit
		Compliance	e Based On:		3. 24 Hour RN	7. Medical Director
12.Total Facility Beds	<b>50</b> (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	VF) 8. Patient Room Size
13.Total Certified Beds	50 (L17)	B Not in Con	pliance with Pro	oram	5. Life Safety Code	9. Beds/Room
15. Total Contined Deus			and/or Applied	-	* Code: A	(L12)
14. LTC CERTIFIED BED BREAK	DOWN				15. FACILITY MEETS	
18 SNF 18/19 SN	IF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
50					()()	
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY RI	EMARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Kathleen Lucas. Dist	rict Suponvisor	0	9/02/2021		Joanne Simon, Enforce	ement Specialist 09/02/2021
Nathleen Lucas, Dis				(L19)		(L20)
F	ART II - TO BE	COMPLETED I	<b>BY HCFA RI</b>	EGIONAI	LOFFICE OR SINGLE S	TATE AGENCY
19. DETERMINATION OF ELIGI	BILITY		IPLIANCE WIT	H CIVIL		ncial Solvency (HCFA-2572)
X 1. Facility is Eligible	to Participate	RIGH	ITS ACT:		<ol> <li>Ownership/Control</li> <li>Both of the Above</li> </ol>	bl Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Elig						
	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	(L30)
OF PARTICIPATION	BEGINNING		ENDING DA		VOLUNTARY _00	
08/01/1982	BEGINNING	JDAIL	ENDING DA	112	01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	-
25. LTC EXTENSION DATE:	27. ALTERNATI	VESANCTIONS	(125)		03-Risk of Involuntary Termination	on OTHER
25. LIC EXTENSION DATE.		n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
	A. Buspension	n of / tallissions.	(L44)			00-Active
(L27)	B. Rescind St	uspension Date:	( )			
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		00131				
	(L28)	00131		(L31)		
	(120)			(131)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE		
	(L32)			(L33)	DETERMINATION APP	ROVAI
	·/			()		



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

An equal opportunity employer.



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



Electronically delivered

September 2, 2021

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

Re: Reinspection Results Event ID: 09ET12

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,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALT	H AND HUMA	N SERVICES			CENTERS FOR MED	ICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: O9ET
	PART I -	TO BE COMPI	LETED BY T	ГНЕ ЅТАТ	TE SURVEY AGENCY	Facility ID: 00655
1. MEDICARE/MEDICAID PROVIDI (L1) 245231	ER NO.	3. NAME AND AD (L3) APPLETON				<ol> <li>TYPE OF ACTION: <u>2</u> (L8)</li> <li>Initial 2. Recertification</li> </ol>
2.STATE VENDOR OR MEDICAID	NO.	(L4) 30 S BEHL S	ST			1. Initial2. Recertification3. Termination4. CHOW
(L2) <b>705040200</b>		(L5) APPLETON	, MN		(L6) <b>56208</b>	5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	PPLIER CATEC	GORY	<u>02</u> (L7)	7. On-Site Visit 9. Other
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 06/30	<b>0/2021</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATION	N	10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b):		0	equirements		2. Technical Personnel	6. Scope of Services Limit
			e Based On:		3. 24 Hour RN	7. Medical Director
12. Total Facility Beds	<b>50</b> (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	F) 8. Patient Room Size
13.Total Certified Beds	<b>50</b> (L17)	X B. Not in Com	pliance with Pro	gram	5. Life Safety Code	9. Beds/Room
			and/or Applied	0	* Code: <b>B</b> *	(L12)
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
50						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION	DATE):		
	X			,		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
<u>Nicole Sassen, HFE - NE</u>	EII	0	8/24/2021		Joanne Simon. Enforce	ment Specialist 09/01/2021
				(L19)		· (L20)
		COMPLETED	<b>SY HCFA RI</b>	EGIONAL	OFFICE OR SINGLE S	IALE AGENCY
19. DETERMINATION OF ELIGIBIL	LITY		IPLIANCE WITI ITS ACT:	H CIVIL		ncial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513)
X 1. Facility is Eligible to F	Participate	NO1			3. Both of the Above	(
2. Facility is not Eligible	e (L21)					
	(221)					
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DA	TE	VOLUNTARY 00	INVOLUNTARY
08/01/1982					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	n <u>OTHER</u>
	A. Suspension	of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	D D	Deter	(L44)			00-Active
	B. Rescind St	spension Date:	(7.4.7)			
	20		(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		00131				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAI	LDATE		
					DETERMINIATION APP	
	(L32)			(L33)	DETERMINATION APPE	OVAL

-



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. <u>If you have not already provided the following information,</u> 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 guality 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

Appleton Area Health July 16, 2021 Page 4 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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm\_</u>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</u>

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

Feel free to contact me if you have questions.

Sincerely,

Kumala 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: <u>Kamala.Fiske-Downing@state.mn.us</u>

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			·		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		0	MB NO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION		E SURVEY PLETED
		245231	B. WING			06/	30/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON AREA HEALTH				0 S BEHL ST PPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00			
	with Appendix Z, Er Requirements, §483	/21, a survey for compliance mergency Preparedness 3.73(b)(6) was conducted ecertification survey. The bliance.					
F 000	signature is not req page of the CMS-28 correction is require	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of the electronic documents. TS	FO	00			
	survey was complet Minnesota Departm your facility was in o of 42 CFR Part 483	1, a standard recertification ted at your facility by the nent of Health to determine if compliance with requirements 5, Subpart B, Requirements for ncilities. Your facility was NOT					
	(IJ) at F689 when R cigarette in the desi using a portable oxy cannula and the oxy turned on. Smoking using oxygen can ra This could result in the residents, staff, Administrator and D were notified of the p.m. on 6/29/21. The removed on 6/30/22 non-compliance ren and severity which is	nained at an isolated scope indicated no actual harm with					
	•	han minimal harm (Level D). DER/SUPPLIER REPRESENTATIVE'S SIGN			TITLE		(X6) DATE
	ically Signed	LINGUFFLIER REFREGENTATIVE S SIGI					07/23/2021

**Electronically Signed** 

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

PRINTED: 08/05/2021

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/05/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245231	B. WING _			06/	30/2021
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON AREA HEALTH				S BEHL ST PPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 000	Continued From pa	ge 1	F 00	00			
		constituted substandard an extended survey was 9/21 to 6/30/21.					
	as your allegation o Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve f compliance upon the otance. Because you are rour signature is not required first page of the CMS-2567 ic submission of the POC will icon of compliance.					
F 550 SS=D	onsite revisit of you validate substantial regulations has bee Resident Rights/Ex	ercise of Rights	F 55	50			8/4/21
	self-determination, access to persons a	nt Rights. right to a dignified existence, and communication with and and services inside and including those specified in					
	with respect and dig resident in a manner promotes maintena her quality of life, re	ility must treat each resident gnity and care for each er and in an environment that nce or enhancement of his or ecognizing each resident's cility must protect and of the resident.					
	access to quality ca	facility must provide equal are regardless of diagnosis, n, or payment source. A facility					

If continuation sheet Page 2 of 52

STATE BURCH OF CORRECTION       INDENTIFICATION NUMBER:       245231       2552       245231       245231       245231       2552       245231       245			AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/05/2021 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS. CITY. STATE. ZIP CODE       30 8 BEHL ST         APPLETON AREA HEALTH       STREET ADDRESS. CITY. STATE. ZIP CODE       30 8 BEHL ST         APPLETON, MR 55208       STREET ADDRESS. CITY. STATE. ZIP CODE       30 8 BEHL ST         APPLETON, MR 55208       STREET ADDRESS. CITY. STATE. ZIP CODE       30 8 BEHL ST         APPLETON, MR 55208       STREET ADDRESS. CITY. STATE. ZIP CODE       30 8 BEHL ST         APPLETON, MR 55208       STREET ADDRESS. CITY. STATE. ZIP CODE       30 8 BEHL ST         APPLETON, MR 55208       STREET ADDRESS. CITY. STATE. ZIP CODE       30 8 BEHL ST         APPLETON, MR 55208       STREET ADDRESS. CITY. STATE. ZIP CODE       30 8 BEHL ST         APPLETON, MR 55208       STREET ADDRESS. CITY. STATE. ZIP CODE       30 8 BEHL ST         APPLETON, MR 55208       STREET ADDRESS. CITY. STATE. ZIP CODE       30 8 BEHL ST         APPLETON, MR 55208       STREET ADDRESS. CITY. STATE. ZIP CODE       30 8 BEHL ST         APPLETON ARCALLERS       STREET ADDRESS. CITY. STATE. ZIP CODE       30 8 BEHL ST         F550       Continued From page 2       F550       F550         F1518       STREET ADDRESS. CITY. STATE. ZIP CODE       20 20 ZET         \$483.10(b)(1)       The facility and a a citizen or resident with respect, dignify and to provide a facility to treat each resident with respect, dignif	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· /		E CONSTRUCTION ()	X3) DATE	SURVEY
MAKE OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY. STATE, ZIP CODE         APPLETON AREA HEALTH       STREET ADDRESS, CITY. STATE, ZIP CODE         (04)10       SUMMARY STATEMENT OF DEFICIENCIES       D         PREFIX       REGULATORY OR LSC DENTIFYING INFORMATION)       PREFIX         7AG       SUMMARY STATEMENT OF DEFICIENCIES       D         PREFIX       REGULATORY OR LSC DENTIFYING INFORMATION)       PREFIX         7AG       SUMMARY STATEMENT OF DEFICIENCIES       D         PREFIX       REGULATORY OR LSC DENTIFYING INFORMATION)       PREFIX         7AG       SUMMARY STATEMENT OF DEFICIENCIES       F550         5483.10(b)(1) <td< td=""><td></td><td></td><td>245231</td><td>B. WING</td><td></td><td></td><td>06/3</td><td>30/2021</td></td<>			245231	B. WING			06/3	30/2021
APPLETON AREA HEALTH         APPLETON, MN 56208           (X4) [D] PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DERICATION SHOLD BE RESOLUTIONY OR LISC IDENTIFITING INFORMATION)         PREFIX PREFIX TAG         PROVIDERS PLAN OF CORRECTION (EACH DERICATION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         OMM           F 550         Continued From page 2 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.         F 550           \$483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:         1.1t 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 with respect. One of several ways this is accomplished is serving our resident with eating. R4's quarterly minimum data set (MDS) dated 32(24/21, indicated moderate cognitive impairment and was independent with eating. R18's quarterly MDS dated 6/2/21, indicated severe cognitive impairment and needed assistance with eating.         1.1t is the policy of this facility to the eating thing experience. One of several ways this accomplished is serving our resident using a steam tables offering real-time choices for warm food items. In addition, our detaivand nursing staff work together to provide a pleasant dining exper	NAME OF F	PROVIDER OR SUPPLIER		1	S	IREET ADDRESS, CITY, STATE, ZIP CODE		
Préfix TAG         CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         PRÉFIX TAG         CEACH CORRENTE COULD DEFICIENCY         Conhight DEFICIENCY           F 550         Continued From page 2 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.         F 550         F 550           §483.10(b) Exercise of Rights. The resident for the facility and as a citizen or resident of the facility and as a citizen or resident of the United States.         F 450           §483.10(b)(1) The facility must ensure that the resrised not an exercise his or her rights as a resident of the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure 3 of 4 residents (R4, R18, and R40) were provided a dignified dining experience. Findings include: Findings include: R4's quarterly minimum data set (MDS) dated 32/4/21, indicated moderate cognitive impairment and was independent with eating. R4's quarterly MDS dated 6/2/21, indicated severe cognitive impairment and needed assistance with eating.         1.It is the policy of this facility to treat each resident with respect, dignly and to provide a dignified dining experience. One of severeal ways this is accompliabled is serving our resident seconditive impairment and was independent with eating.           R18's quarterly MDS dated 6/2/21, indicated severe cognitive impairment and needed assistance with eating.         1.It is the policy of this facility to treat each resident with cac	APPLET	ON AREA HEALTH						
<ul> <li>It is the policy of this facility to treat each resident with respect, dignity and to provide a dignified dining experience.</li> <li>Findings include:</li> <li>R4's quarterly minimum data set (MDS) dated 3/24/21, indicated moderate cognitive impairment and needed assistance with eating.</li> </ul>	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
R40's significant change MDS dated 4/19/21, facility are potentially affected by the cited	F 550	must establish and practices regarding provision of service residents regardles §483.10(b) Exercise The resident has the rights as a resident or resident of the U §483.10(b)(1) The for- resident can exercise interference, coerci- from the facility. §483.10(b)(2) The for- free of interference reprisal from the fac- rights and to be sup exercise of his or he subpart. This REQUIREMENT by: Based on observant review the facility fac- (R4, R18, and R40) dining experience. Findings include: R4's quarterly minina 3/24/21, indicated mand was independent R18's quarterly MD severe cognitive im assistance with eat	maintain identical policies and transfer, discharge, and the s under the State plan for all s of payment source. e of Rights. e right to exercise his or her of the facility and as a citizen nited States. facility must ensure that the se his or her rights without on, discrimination, or reprisal resident has the right to be coercion, discrimination, and cility in exercising his or her oported by the facility in the er rights as required under this NT is not met as evidenced tion, interview, and record iled to ensure 3 of 4 residents of were provided a dignified num data set (MDS) dated noderate cognitive impairment ont with eating. S dated 6/2/21, indicated pairment and needed ing.	F 5	550	each resident with respect, dignity ar provide a dignified dining experience of several ways this is accomplished serving our resident using a steam ta offering real-time choices for warm for items. In addition, our dietary and nu staff work together to provide a pleas dining experience. In this case, after surveyor reported residents receiving meals at different times while seated the same table, nursing staff was reminded to serve one table at a time before moving to the next table. 2.All residents receiving meals at this	nd to a. One is ables ood ursing sant the g I at e s	

Facility ID: 00655

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		E SURVEY
ND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	СОМ	PLETED
		245231	B. WING		06/:	30/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON AREA HEALTH			30 S BEHL ST APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 550	required supervision During observation unknown dietary ai and R18 were alrea Other residents in of they want for meals what they wanted to During observation R40 reached across food. R4 stated "the were in the dining r from staff. During observation received her meal. During observation received her meal to up food at table at During interview or aide (DA)-A stated individuals at that se their meals at the se fair nor acceptable at the same table of During interview of medication aide (The passing meal trays be serving everyon moving to the next was not ok for one	on 6/28/21, at 11:57 a.m. d brought R4 her meal. R40 ady sitting at table with R4. dining room being asked what s. No one asked R40 or R18 o eat. on 06/28/21, at 12:05 p.m. is table and took a bite of R4's at is mine". Other individuals room receiving there meals on 6/28/21, at 12:07 R40 on 6/28/21, at 12:07 R40 on 6/28/21, at 12:11 p.m. 18 tray. Staff assisting with cutting table 1. n 6/29/21, at 12:44 p.m. dietary when passing out trays all same table should be delivered same time. DA-A stated it is not for residents to watch others	F 550		irector of d nursing ng on on erience. dents ed before ey for as been dure which . The udes a the dining ee will er week y x2. orted to d action, tee will	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/05/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245231	B. WING			06/3	30/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON AREA HEALTH				30 S BEHL ST APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550 F 554 SS=D	tag and then find th and ask them what further stated there the staff grab first. I serving everyone at the next. LPN-B fur have one person se having to wait. LPN would be upset". During interview on registered nurse (R has now changed to room. RN-A stated the processes in the indicated it is a digr resident served the table just waiting. During interview on director of nursing ( should be served of ok otherwise. DON someone eating in Requested policy for policy regarding this assistance with mea Resident Self-Admi CFR(s): 483.10(c)(7) §483.10(c)(7) The r medications if the ir defined by §483.21	N)-B stated staff grab a name e resident in the dining room they would like to eat. LPN-B is no rhyme or reason to who .PN-B stated they should be the table before moving on to ther stated it is not right to erved first and then the others -B stated if that was me "I 6/29/21, at 4:59 p.m. N)-A stated the dining process o residents eating in the dining they need to work on some of e dining room. RN-A further ity issue when you have one ir meal and the others at the 6/30/21, at 10:35 a.m. the DON) stated all residents ne table at a time and it is not further stated "I wouldn't want my face while I am waiting". or dining room procedure: no s. Facility did supply policy for als expired 6/21. n Meds-Clinically Approp 7) ight to self-administer nterdisciplinary team, as (b)(2)(ii), has determined that		550			8/4/21

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STATEMENT	OF DEFICIENCIES OF CORRECTION	K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
				G		
		245231	B. WING			30/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 30 S BEHL ST	, ZIP CODE	
APPLET	ON AREA HEALTH			APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 554		tion, interview and record	F 55	4 1.It is the policy of this administer medication		
	self-administration	of medication for 1 of 1 ewed for self-administration of		federal regulations and of practice. One of sev accomplished is reside	d nursing standards veral ways this is ent identification	
	Findings include:			using a photo in the El administering medicati TMA is delegated by th	ion. Additionally, the	
	moderate cognitive able to understand	24/21, indicated R5 had impairment and was usually others. R5's diagnosis l's, schizoaffective disorder		medication administrat manner. In this case, a reported medication w for R5 to self-administe negatively impacted by	after the surveyor as left unattended er; R5 was not / the cited	
	6/29/21, trained me R5 prefers his med setting up his medi room and stated R ready. TMA-A proc medications in a pl	of medication pass on edication aid (TMA)-A stated dications in applesauce. After ications, TMA-A left them in his 5 will take them when he is eeded to set up three oral astic medication up. TMA-A ce into a separate medication		deficiency. TMAs were medication should not resident that has no pr self-administration and administration assessr 2.All residents that do self-administration ass provider order are pote the cited deficiency.	be left with any ovider order for a self ment. not have a sessment and no	
	cup. TMA-A brough R5's room, placed chair and told him to acknowledged TM/ to reach for either of TMA-A leaving the	nt both medications cups to them on the table next to his they were there. R5 A-A but did not make attempts of the medication cups prior to room. TMA-A explained she om approximately one hour		3.To enhance the Care administration practice Nursing or designee w nurses and TMA s on Self-Administration of 4.Director of Nursing o daily medication admir	es, the Director of ill in-service license i the facility policy, Medication. or designee will audit histration of TMA□s	
	after leaving the me them. TMA-A state him after approxim take his medication doing." TMA-A was	edications to check if he took d, usually after the checking on ately three times, he will then ns, "He knows what he is not aware if R5 had been se to determine if he was safe		weekly x3, then month audits will be reported committee for review a appropriate. The QA co determine the need for and/or action plan.	to the QA and action, as ommittee will	
		2 a.m. RN-A stated residents -administer medications				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/05/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245231	B. WING			06/:	30/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON AREA HEALTH				0 S BEHL ST PPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 554 F 577 SS=C	without being assess The TMA would knows self-administer media be a message on the resident, on the media RN-A confirmed R5 self-administer his in should not be left with TMA to remain with his medications. on 6/30/21, at 1:53 stated before a resident and an order of expected staff to allor resident requested medications. Facility policy, Self- revised 6/2017, india who wish to self-add do so, if it is determine so. Right to Survey Res CFR(s): 483.10(g)(10) \$483.10(g)(10) The (i) Examine the resident respect to the facilitit (ii) Receive information	Administration of Medications, icated residents in the facility minister their medications may ined they are capable of doing sults/Advocate Agency Info 10)(11) eresident has the right to- ults of the most recent survey cted by Federal or State plan of correction in effect with ty; and tion from agencies acting as able to self-administer survey check the successfully took	F 5				8/4/21

Facility ID: 00655

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	OF DEFICIENCIES	& MEDICAID SERVICES	(Y2) MULTI	PLE CONSTRUCTION	OMB NO.	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,	G	· · ·	PLETED
		245231	B. WING _		06/	30/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON AREA HEALTH			30 S BEHL ST APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 577	Continued From pa	qe 7	F 57	7		
	<ul> <li>(i) Post in a place reand family member residents, the result the facility.</li> <li>(ii) Have reports wit certifications, and corespecting the facility years, and any plan respect to the facility to review upon requires of the facility accessible to the port (iii) Post notice of the areas of the facility shall information about coreview, the facility faces and visito potential to affect at the facility and all visits potential to affect at the facility and all visits of the facility and all visits of four above the facility and all visits of four above the facility and all visits of four above the facility of the facility and all visits of four above the facility of the facility and all visits of four above the facility of the facility and all visits of four above the facility of the facility and all visits of four above the facility of the facility and all visits of four above the facility of the facility and all visits of four above the facility of the facility and all visits of four above the facility of the facility and all visits of four above the facility of the facility and all visits of four above the facility of the facility and all visits of four above the facility of the facility of the facility and the facility and</li></ul>	eadily accessible to residents, is and legal representatives of ts of the most recent survey of th respect to any surveys, complaint investigations made ty during the 3 preceding of correction in effect with ty, available for any individual uest; and ne availability of such reports in that are prominent and ublic. I not make available identifying omplainants or residents. NT is not met as evidenced tion, interview and document ailed to ensure three years of e readily accessible for rs review. This had the II 43 residents who resided in		1.It is the policy of this facility to state and federal regulations relaresident rights, specifically havin available the Department of Hearesults for residents, family mem legal guardians to view as neces 3 rings □ binder available labeled results was updated to contain 3 survey results on 6/30/21. The administrative assistant was rem 6/30/21 that survey results shoul easily accessible according to fa policy Posting Care Center Surve 2. All residents, family members, guardians and visitors are potern affected by the cited deficiency. 3. To enhance the Care Center o and under the direction of the Di Nursing or designee, the care ce leadership, and administrative assistant was remented affected by the cited deficiency.	ated to g readily lth survey bers and sary. The survey years of inded on d be cility ey. legal tially perations rector of enter	

Facility ID: 00655

TATEMENT	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	OMB NO	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		IG	· · ·	IPLETED
		245231	B. WING _		06/	30/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON AREA HEALTH			30 S BEHL ST APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 577	Continued From pa	ige 8	F 57	7		
	On 6/30/21, at 12:5 representative (SR contained only the results. SR stated s recent annual surve unaware survey res	1 p.m. the staffing/billing confirmed that the binder 3/21/19, and 10/21/19, survey she thought only the most ey was required and was sults from the three preceding available for residents and		4.Social Services or designee w survey binder twice monthly for Results of the audits will be rep- the QA committee for review an as appropriate. The QA commit determine the need for further a and/or action plan.	6 months. orted to d action, tee will	
	nursing (DON) ack certifications, and c regarding the facilit	p.m. the interim director of nowledged that any surveys, complaint investigations made y during the three preceding available for residents and				
F 677 SS=D	results dated 07/20 must be in an easil survey results, cert investigations made the 3 preceding yea correction. The poli accessibility to thes prominent [sic] and Additionally, the po results will be main "Survey Results" and the Care Center. ADL Care Provided	osting Care Center Survey 21, indicated survey results y accessible location, contain ifications, and complaint e respecting the facility during ars; as well as, any plan of icy further indicated notice of e results should be posted in accessible to the public. licy indicated the survey tained in a binder well labeled and kept at the main entrance to I for Dependent Residents 2)	F 67	77		8/4/21
	§483.24(a)(2) A res out activities of dail services to maintain personal and oral h	sident who is unable to carry y living receives the necessary n good nutrition, grooming, and				

Facility ID: 00655

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		0938-039 E SURVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		245231	B. WING		06/:	30/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON AREA HEALTH			30 S BEHL ST APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 677	Based on observat review, the facility f offered or provided R27) in the sample staff for assistance (ADLs). Findings include: R25's face sheet un included acute on of heart failure, adjust mood, major depre obstructive pulmon disorder. R25's quarterly min 5/4/21, indicated m R25's MDS further of one assist for dro R25's care plan rev resident has an AD r/t chronic diastolic effusion, moderate atrial fibrillation hyp with pacemaker, hy history of depression the resident prefers sha shave on own after Clean shaver for th During observation 12:42 p.m. R25 wat approximately 1/4 i	tion, interview and document ailed to ensure shaving was for 2 of 3 residents (R25 and who were dependent upon with activities of daily living and the disorder diagnosis chronic diastolic (congestive) ment disorder with depressed ssive disorder, chronic ary disease, and anxiety any disease, and anxiety and personal hygiene. Any degree avelock any deficit. Paroxysmal ertension, 3rd degree avelock any disease and anxiety and any with interventions listed as and dressing/grooming routine atfast. Personal hygiene: the ave every morning. Able to set up. Touch up as needed. e resident. and interview on 6/28/21, at s sitting in recliner and had nch facial hair covering and below nose. Hair	F 677	<ul> <li>1.It is the policy of this facility to state and federal regulations, spe ADL care provided for dependent residents. Resident R25, R27 wa on 6/30/21, the care plan prefere shaving were reviewed with R25, 7/22/21 updated per preference.</li> <li>2.All residents that are dependent have facial hair are potentially aff the cited deficiency. Residents the dependent preferences will be cla and care plan updated.</li> <li>3.To enhance the Care Center pr and under the direction of the Dir Nursing or designee, the nursing be in-serviced on ADL care providependent residents.</li> <li>4.Director of Nursing or designee resident grooming 3 times per we then monthly x4. Results of the abe reported to the QA committee review and action, as appropriate committee will determine the need further audits and/or action plan.</li> </ul>	ecifically s shaved nces for R27 on t and ected by at are arified actices ector of staff will ded for e will audit eek x 4, audits will for e. The QA	

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		AND HUMAN SERVICES				FORM	08/05/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245231	B. WING			06/:	30/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON AREA HEALTH			-	0 S BEHL ST APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	Continued From particle they are going to he During observation sitting in his recline unshaven, hair remon face and chin with hair. During observation 10:02 a.m. R25 was unshaven with apprand white hair on far stated "I would like today". During interview on medication aide (Th assistance of one for dressing, and shave the dressing, and shave the dressing, and shave the dressing of the compractical nurse (LPI assistance with car R25 can shave him do so. LPN-A stated	age 10 elp him with shaving today. on 06/28/21, 7:28 p.m. R25 r and continued to be hain approximately 1/4 in. long hich was, coarse gray/white and interview on 06/29/21, at s sitting in recliner, remained roximately 1/4 in coarse gray ace, chin and neck. R25 to be shaved some time of 6/29/21, at 12:59 p.m. trained MA)-A stated that R25 is or all cares including bathing,	TAG			NATE	DATE
	best. During interview on assistant (NA)-B sta getting R25 cloths of process of cleaning that it was important wanted to be shave on the residents ca she had not shaved help with residents	eryone wants to look their 6/29/21, at 2:15 p.m. nursing ated she had just finished changed and was in the g up the room. NA-B stated ht to shave all men who ed and this would be indicated re plan. NA-B further stated d R25 as she usually does not getting up in the morning.					

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	08/05/2021 APPROVED 0938-0391
STATEMENT OF DEFIC	IENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE	E SURVEY IPLETED
		245231	B. WING _			06/:	30/2021
NAME OF PROVIDER	OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
APPLETON AREA	HEALTH				S BEHL ST PPLETON, MN 56208		
PREFIX (EAG	CH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
<ul> <li>wasn't sishaved stated sishaved stated signated signated signated signated to a refused be docurroom.</li> <li>During stated ti appears</li> <li>R27's Funspect disturbation combining and the signated signated signated signated signate si</li></ul>	can help the she can go k aving. NA-B e will usually the nurse s umented. NA interview on hat all men ance, if they face sheet u ified demen ance, deliriu on, and anxie guarterly MD the cognitive ed R27 requing and person g hair, brush are plan rev dent has an with interven g/grooming ist. observation .m. R27 had gray/white h iose. R27 st is to have his time he was	<ul> <li>and interview on 6/29/21, at d approximately 1/4 inch hair on cheeks, chin, neck, and taxet of charter of charte</li></ul>	F 67	77			

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		AND HUMAN SERVICES				FORM	08/05/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245231	B. WING	i		06/;	30/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON AREA HEALTH				0 S BEHL ST APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	Continued From pa R27 facial hair note	-	F€	677			
	walking down hallw	on 6/29/21, at 12:16 p.m. R27 ay continue to have n. coarse gray/white hair on					
	practical nurse (LPI assistance of 1 with	6/29/21, at 1:28 p.m. license N)-A stated R27 requires a all morning and afternoon aving and oral cares, which viding to him.					
	assistant (NA)-B sta	6/29/21, at 2:15 p.m. nursing ated all men should be shaved rence and should be offered					
	registered nurse (R himself if you cue h important to assist identify the problem	6/29/21, at 5:16 p.m. N)-B stated R27 can shave im. RN-B also stated it is with grooming as they can't n themselves and R27 is a very want him to have good					
	was walking down h	on 6/30/21, at 7:14 a.m. R27 hallway with front wheeled ed to have facial hair on face					
	stated R27 has den with shaving. NA-C attempted to shave was full of hair and clean it. NA-C state should be shaved d	6/30/21, at 8:43 a.m. NA-C nentia and needs assistance further stated she had him this morning but his razor needed to find a brush to ed all men, if they prefer it, daily for appearance and R27 I it is important to him to have					

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		AND HUMAN SERVICES				FORM	08/05/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245231	B. WING			06/:	30/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON AREA HEALTH				) S BEHL ST PPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	appeared R27 has days which is not of During interview on director of nursing ( and women should growing and they put further stated it is n be shaved. DON st a dignity issue along can get caught in th Shaving the resider indicated "The purp promote cleanlines: Notify the supervise procedure". Activities of Daily Li indicated "residents activities of daily livit the services necess grooming, and pers Care plan-Compret expires 6/21, indica person-centered ca measurable objectiv resident"s physical, needs is developed resident". Quality of Care	NA-C further stated it not been shaved for many k as he likes his hair short. 6/30/21, at 10:35 a.m. the (DON) stated that both men be shaved if they have hair refer it to be shaved. DON ot acceptable for men to not ated not being shaved can be g with harbor germs as food	F 6				8/4/21
SS=E	§ 483.25 Quality of Quality of care is a	care fundamental principle that lent and care provided to					

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		& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION ()		SURVEY
		245231	B. WING			06/3	0/2021
NAME OF	PROVIDER OR SUPPLIER	-		ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON AREA HEALTH				) S BEHL ST PPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 684	facility residents. Ba assessment of a re that residents recei accordance with pr practice, the compr care plan, and the n This REQUIREMEN by: Based on observat review the facility fa monitoring weights and R25), the facilit 1 of 1 residents (R2 failed to notify provi for a blood sugar re range. Findings include: R25's face sheet un included acute on of heart failure, adjust mood, major depre obstructive pulmon disorder. R25's quarterly min 5/4/21, indicated m R25's care plan rev resident has an act self-care performar	ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of rehensive person-centered residents' choices. NT is not met as evidenced tion, interview, and document ailed to follow orders for for 4 of 4 residents (R3, R24, ty failed to assess bruising for 13). In addition, the facility ider for 1 of 1 residents (R41) eadings above a specified thronic diastolic (congestive) ment disorder with depressed ssive disorder, chronic ary disease, and anxiety timum data set (MDS) dated oderate cognitive impairment. indicated need for assistance essing and personal hygiene.	F 64	84	It is the policy of this facility to abide state and federal regulations, specific quality of care related to following providers orders for monitoring weigh for R3, R24, & R25, notifying the pro- for blood sugar reading above the specified range for R41, and assessi bruise for R13. a.Weights were completed for R3 on 6/29/21, R24 on 6/29/21, R25 on 7/1, R3, R24, & R25 was not negatively impacted by the cited deficiency. Th dietician was notified on 7/1/21 for R2 change in weight, and responsible party notified 6/29 & R3 responsible party notified on 6/30. b.R13 was not negatively impacted b cited deficiency R13 was assessed of 6/29/21. Long sleeves shirt was implemented on 6/29/21. Protective sleeves were initiated on 6/30/21 and plan was updated with protective sleet to reduce bruising on 7/5/21. c.R41 was not negatively impacted b cited deficiency R41 responsible party	cally hts, vider ing a n /21. e 25 arty 25 arty was by the on otified d care eves by the	
	moderate cognitive indicated the reside	pleural effusion, and deficit. R25's care plan further ent has congestive heart failure uld be monitored weekly.			cited deficiency R41 responsible part was notified on 6/29/21 and the provi was notified on (6/29/21) 1.All residents are potentially affected relative to provider orders and bruisir	ider d	

Facility ID: 00655

STATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
	ST CONTRECTION	IDENTIFICATION NONDER.	A. BUILDING	A. BUILDING			
		245231	B. WING			06/3	30/2021
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON AREA HEALTH				S BEHL ST PLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIO DATE
F 684	Continued From pa	age 15	F 684	4			
	R25's weight calcul 05/19/2021, the res 06/16/2021, the res which is a -5.52 % R25's cardiology no impression included evidence of pulmor fluid in the lungs), I benefit from increas failure. Recommen amlodipine to 10 m make his periphera zaroxolyn 2.5 mg b morning with his La pulmonary congest R25's provider orde (diuretic) 80 mg by and 40 mg by mout Progress note date indicated new ordet per week, one time Wednesday, and F resident is on isolat Staff care guide sho indicated R25 shou Wednesdays. R25's weight list da weight done on 6/1 other documentatio	lations percentage loss on sident weighed 204.6 lbs. On sident weighed 193.3 pounds Loss. ote dated 6/4/21, clinical d: marked edema with hary vascular congestion (extra believe this patient would sed diuretics, chronic heart dation included changing g as amlodipine is likely to al edema worse. Start y mouth every other day in the asix to see if we can reduce his ion and peripheral edema. ers dated 6/19/21 Lasix mouth every morning for CHF th every evening for CHF. d 6/23/21, at 11:20 am r to obtain weights three times a day every Monday, riday for weight loss and tion precautions for C-diff. eets updated 6/29/21,			Resident with specified blood sugaranges is also potentially affected licited deficiency. a.Blood sugar parameters were accessidents with specified ranges to a alert on the dashboard. Nursing leadership will audit dashboard in a meeting. b.Skin assessment was completed residents on 7/23/21 thru 7/26/21 2.To enhance the Care Center clin practice and under the direction of Director of Nursing or designee, the nursing staff will be in-serviced on following provider orders for weigh blood sugars with specified ranges assessing and reporting bruising, a completing weekly skin assessment/documentation. 3.Director of Nursing or designee weekly, blood sugars with specifier ranges in daily in clinical meeting weekly, blood sugars with specifier ranges in daily in clinical meeting weekly at ther monthly x2. Results of the audits we reported to the QA committee for r and action, as appropriate. The Q/ committee will determine the need further audits and/or action plan.	by the dded to create clinical d on all ical the ts, s, and will audit e than d with no ndomly n will be eview A	
		6/29/21, at 12:59 p.m. trained MA)-A indicated resident is to					

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		AND HUMAN SERVICES				FORM	08/05/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
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APPLET	ON AREA HEALTH				0 S BEHL ST PPLETON, MN 56208		
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F 684	his current infection nursing assistants ( mark them on the c and enter into the c was important to we they are stable and weight. During interview on practical nurse (LPI diagnosis of c-diff a weights due to weig now they have no w his room due to bei he thinks they could clean the machine, attention of the regi confirmed R25 sho times a week Mond and stated "It was a order". LPN-A state weight loss with R2 computer while talk classify his weight I LPN-A further state should be notified a During interview on stated R25 should I which was Wedness nurse if he refused. to weigh residents to stable. During interview on stated R25 was put has c-diff and it was	age 16 eights due to weight loss and of c-diff. TMA stated the (NA) weigh the residents and clipboard the nurses will review computer. TMA further stated it eigh residents to make sure not losing or gaining to much 6/29/21, at 1:15 p.m. licensed N)-A stated R25 has a and staff are monitoring his ght loss. LPN-A stated right vay of weighing him outside of ng on precautions, however d use the hoyer lift and just but has not brought this to the stered nurses. LPN-A uld be being weighed three lay, Wednesday and Friday, a nursing order not a provider ed he was not aware of any 5 until he looked into the ting and stated he would oss as a significant loss. d the provider and dietician as well to further monitor. 6/29/21, at 2:15 p.m. NA-B be weighed on his bath days day and then reported to the NA-B stated it was important to make sure their weights are 6/29/21, at 4:14 p.m. Dietician con strong diuretics and now s important to monitor his the has not lost any more	F 6	584			

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		AND HUMAN SERVICES				FORM	08/05/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON AREA HEALTH				0 S BEHL ST APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	weight. The dieticia was up to 204, but 193 and stated they weight to make sur- weight. The Dieticia that was put in by n times a week weigh be weighting him. During interview on registered nurse (R residents should be however with R25 t just put in for three stated she would be residents and if the that it should be rep stated it was import he was on diuretics status and c-diff. During interview on stated R25 should t times a week and if should be done ond it is not ok to go a n and it is important to being on diuretics a for a decline in statu During interview on director of nursing ( a weight that states she would expect th three times a week aware that he was n way of weighing R2 stated there are wa	In stated she sees his weight he is now back to baseline at y should be monitoring his e he is not losing anymore an stated she sees an order hursing on 6/18/21 for three hts and would expect staff to 6/29/21, at 4:51 p.m. EN)-A stated in general all e weighed at least weekly, here was an order that was times a week weights. RN-A e expecting staff to weigh y were unable to weigh him ported to the RN's. RN-A tant to monitor R25's weight as a and due to his nutritional 6/29/21, at 5:05 p.m. RN-B be monitored for weigh three f no specific order all residents ce a week. RN-B further stated nonth without being weighed o monitor his weights due to and c-diff and should monitor	F	\$84			

		AND HUMAN SERVICES				FORM	08/05/2021 APPROVED 0938-0391
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F 684	scale or bringing re residents were in th precautions. DON s weigh R25 to monit he is not losing to m weight with the diur Weight assessmen expires 6/21, "The n strive to prevent, m undesirable weight Weights will be recor- record chart or note medical record. Any more since the last retaken the next da weight is verified nu- the dietitian in writing R41's Facesheet un diabetes type 2 with diabetes mellitus wi disease, and essen R41's quarterly MD cognitive impairmen R41's provider orde Novolog FlexPen S UNIT/ML (Insulin As down blood sugar) - 149 = 0; 150 - 200 = 6; 301 - 350 = 8; subcutaneously bef	sident out when no other ne hallway to keep isolation stated it was important to cor his status and make sure nuch weight or regaining retics. t and intervention policy multidisciplinary team will onitor, and intervene for loss for our residents. orded in each unit's weight abook and in the individual's y weight change of 5% or weight assessment will be by for confirmation. If the ursing will immediately notify ng. Verbal notification be "." ndated, indicated diagnosis: n diabetic polyneuropathy, ith diabetic chronic kidney itial hypertension. S dated 6/3/21, identified no nt. ers dated 6/29/21, indicated olution Pen-injector 100 spart) (medication to bring Inject as per sliding scale: if 0 0 = 2; 201 - 250 = 4; 251 - 300 351 - 999 = 10 to Notify MD, fore meals and at bedtime DIABETES MELLITUS	F	584			

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		AND HUMAN SERVICES				FORM	08/05/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
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F 684	R41's weights and y indicated blood sug 442 and then on 6/7 was 411. During interview on stated he was awar 442 on 6/28/21, but R41 eating ice crea use your common s provider orders how R41's bad habits. L provider orders how R41's bad habits. L provider shave acco can see his results. and assessed R41 symptoms so he ga follow the order and stated he could not 6/28/21 nor 6/15/21 elevated. During interview on Dietician reviewed I residents blood sug providers orders the notified and is unact the provider. The di important to notify p as it could mean the adjusted or there is the resident. During interview on nurse (RN)-B stated was 442 she would provider and it was not to notify the pro	inge 19 vital summary dated 6/29/21, jar on 6/28/21 at 12:01 was 15/21 at 10:51 pm blood sugar 6/29/21, at 1:05 p.m. LPN-A re of R41's blood sugar was a stated "I knew it was from im and sometimes you have to sense and I did not notify the ated you should follow the vever with him it is due to PN-A further stated the ess to his point click care and LPN-A stated he went down and he wasn't having ave him his insulin but did not d notify the provider. LPN-A find documentation on when blood sugars where 6/29/21, at 4:22 p.m. the Novolog orders and stated if gar was 442 according to e provider should of been sceptable for staff not to notify ietician further stated it is provider of high blood sugars eir medications need to be something else going on with 6/29/21, at 5:12 registered d if a residents blood sugar expect staff to notify the unacceptable for the nurse vider even if the resident ate ated it was important to follow	Fθ	\$84			

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		AND HUMAN SERVICES				FORM	08/05/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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F 684	Continued From pa providers orders. During interview on director of nursing ( R41's Novolog ordet the nurse should be and calling the provistandards to follow provider if the order out of the normal de DON further stated provider in case the medication. DON fu changing the setting point click care as if sure an outcome w Diabetes-Clinical pr " The physician will episodes associate change in blood sug of previous glucose	nge 20 6/30/21, at 10:35 a.m. the (DON) stated according to ers any blood sugar over 351 e giving him 10 units of insulin vider. DON stated it is nursing provider orders and notify the r states to or the blood sugar is espite R41 having ice cream. it was important to notify the e provider needed to adjust his urther stated she will be gs for his orders/parameter in t has the capability to make as completed. rotocol expires 6/21, indicated follow up on any acute ed with a significant sustained gars or significant deterioration e control and document	ľ	584	DEFICIENCY)		
	situation is resolved desired parameters information related The staff will incorp the medication adm plan. The staff will i may affect, or be af and diabetes mana skin ulceration, incr ". Nursing care of res expires 6/21, indica individuals with diab relevant protocols a	ubsequent visits until the acute d. The physician will order s for monitoring and reporting to blood sugar management. Horate such parameters into hinistration record and care dentify and report issues that ffected by a patient's diabetes gement such as foot infection, reased thirst, or hypoglycemia. ident with diabetes mellitus ated "The management of betes mellitus should follow and guidelines. The physician ency of glucose monitoring".					

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
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F 684	Continued From pa	ge 21	F 68	34			
	was severely cognit sometimes able to diagnoses included hypertension and h move her upper ext During observation was noted to have a that started at her v approximately halfv elbow. The bruise a The bruise was at v noted was a large, o the base of her left back of her hand. F scattered, deep pur R13 was not able to bruises. Progress notes faile There were no skin during 6/2021. On 6/29/21, at 12:4 (NA)-A confirmed th arms and stated sh bruising but was no there. NA-A explain nurse, when doing of what it is. If it is som that resident, such would first talk with nursing assistant, to reported. NA-A did	S dated 4/6/21, indicated R13 tively impaired, she was make herself understood and understand others. R13's dementia, diabetes, anxiety, eart failure. R13 was able to tremities without limitations. on 6/28/21, at 12:05 p.m. R13 a large bruise on her left arm vrist and extended to vay between her wrist and her also wrapped around her arm. various stages of healing. Also deep purple bruise starting at thumb and extended to the R13 had several smaller, ple bruises on her right arm. o explain how she got the ed to identify the bruising. assessments completed 8 p.m. nursing assistant he bruising on both R13's e had previously noted the t sure how long they had been ed what she reports to the daily skin checks, depends on nething that is common for as the bruising is for R13, she her co-worker, another o decide if it needs to be not recognize the bruising on was not sure if she would have					

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PRINTED: 08/05/2021

	RINTED: 08/05/2021 FORM APPROVED MB NO. 0938-0391									
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE SURVEY COMPLETED				
		245231	B. WING			06/:	30/2021			
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-				
APPLETON AREA HEALTH				30 S BEHL ST APPLETON, MN 56208						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 684	another nursing ass does not become p resistive with cares around when she g On 6/29/21, at 1:45 (LPN)-A confirmed on R13' arms but w happened. LPN-A c monitoring the bruis progress notes. On 6/29/21, at 2:09 bruises located on t is given her call ligh use it. She would of staff attention. LPN previously made not and discussions wit bruising. LPN-B's n not received. On 6/29/21, at 2:17 stated she expected changes, including nurse and document reported skin conce be documented in t and appearance. B monitored either dat the severity of it. Br decide the cause at RN-B indicated she bruises on her arms and varied stages of On 6/30/21, at 1:50	ating she would talk with sistant first. NA-A stated R13 hysically aggressive or but does swing her arms ets excited and is happy. 6 p.m. licensed practical nurse he was aware of the bruising vas not aware of how they confirmed they were not sing or documenting in the 9 p.m. LPN-B confirmed the R13's arms. She stated, R13 nt, but does not consistently ften slap her arms to get the -B indicated she had made otes regarding R13's bruising th R13's daughter about the lotes were requested but were 7 p.m. registered nurse (RN)-B d all skin concerns or bruising, were reported to the nted. This included previously erns. Reported bruises should the progress notes with size ruising should then be ally or weekly, depending on uses are investigated to nd how to avoid recurrence. was not aware of R13's s, but confirmed size, location of healing.	F	584	DEFICIENCY)					
		p.m. director of nursing ning that was seen, new or								

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DEPARTM CENTERS	RINTED: 08/05/2021 FORM APPROVED MB NO. 0938-0391						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
245231			B. WING			06/30/2021	
NAME OF PRO	OVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
APPLETON AREA HEALTH					0 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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
ebadınım ArerRinhefambd R3.ft.ft.c. Rire(İkicisi vi p.w. R5.	<ul> <li>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</li> <li>Continued From page 23</li> <li>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.</li> <li>A facility policy regarding skin checks was requested but was not received.</li> <li>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.</li> <li>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.</li> <li>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.</li> </ul>		F	\$84			

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		AND HUMAN SERVICES				FORM	08/05/2021 APPROVED 0938-0391
STATEMENT	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245231	B. WING			06/30/2021	
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON AREA HEALTH				0 S BEHL ST APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	R3's signed provide 5/13/21, indicated r by mouth one time related to localized Additionally, provide bumetanide (diureti day related to unsp heart failure. R3's weight summa documented weight were obtained 1/8/2 2/2/21, 2/5/21, 2/9/2 3/5/21, 3/9/21, 3/12 3/31/21, 4/8/21, 4/9 5/4/21, 5/5/21, 5/7/2 6/1/21, 6/8/21, 6/15 During interview on practical nurse (LPI weight taken on Tu- R3's electronic hea stated "I see the or Wednesday, Friday LPN-B further state only one time a wea weights was "overal During interview on registered nurse ca charge nurse monit stated the charge n prior to provider vis were requested, an standup meetings. orders were not foll During interview on	er order summary dated metolazone (diuretic) 2.5 mg a day every Mon, Wed, Fri edema was initiated 11/13/17. er order dated 1/24/20, ic) 1 mg by mouth two times a pecified diastolic (congestive) ary dated 7/1/21, indicated ts from the last six months 21, 1/19/21, 1/22/21, 1/29/21, 21, 2/16/21, 2/23/21, 3/2/21, 2/21, 3/16/21, 3/23/21, 3/26/21, 3/21, 4/13/21, 4/20/21, 4/27/21, 21, 5/11/21, 5/18,21, 5/25/21, 5/21, and 6/29/21. a 6/30/21, at 9:29 a.m. licensed N)-B stated that R3 had her esdays. As LPN-B reviewed lth record (EHR), LPN-B der now for Monday, 7. It needs to be adjusted." ed R3 wanted to be weighed ek and the management of	F 6	i84			

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		AND HUMAN SERVICES				FORM	08/05/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245231	B. WING			06/	30/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
APPLET	ON AREA HEALTH				0 S BEHL ST APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	expected to follow p nurses were expect DON further stated weighed, she would completed an asses provider after the re Additionally, the DC to be followed as w discontinued or cha R24's quarterly MD R24 was cognitively wheelchair for locor assistance/supervis The MDS identified congestive heart fa kidney failure, and of R24's care plan dat intervention to weig which was to be con under the same cor clothing. R24's order summa order for daily weig congestive heart fa 1/26/21, and no end R24's treatment ad lacked documentati 104 days between 2 explanation of miss R24's progress note During interview on stated she expected followed. She stated complete she expected	brovider orders for weights and ted to monitor weights. The if a resident refused to be d expect the nurse to ssment and notified the esident's third refusal. ON stated she expected orders ritten until they were anged. S dated 4/29/21, indicated y intact, used a walker or motion, and required limited sion with walking and toileting. diagnoses which included ilure, high blood pressure, dementia. ted 2/14/21, included an the R24 as ordered by provider mpleted at the same time nditions with same amount of ary report contained a provider hts relating to diagnosis of ilure with a start date of d date. ministration record (TAR) ion of daily weights on 30 of 2/15/21, and 6/28/21. No sing values were recorded on	F	584			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FOI	ED: 08/05/2021 RM APPROVED IO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY COMPLETED
		245231	B. WING			06/30/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
APPLET	ON AREA HEALTH				0 S BEHL ST PPLETON, MN 56208	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From pa	ge 26	F6	384		
	and stated she obse TAR and acknowled documented as hav were recorded in R She stated they [sta was not completed, weights would be re- when completed. Free of Accident Ha CFR(s): 483.25(d)(1) §483.25(d) Accident The facility must en §483.25(d)(1) The r as free of accident H §483.25(d)(2)Each supervision and ass accidents. This REQUIREMEN by: Based on observat review, the facility fa protective measure residents who were smoke while using residents (R23) who the facility. The defi Immediate Jeopard at risk for significan smoking while oxyg The IJ began on 6/2 was observed smok designated smoking	ts. sure that - resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent NT is not met as evidenced ion, interview, and document ailed to establish adequate s and supervision to ensure dependent on oxygen did not portable oxygen for 1 of 4 o were listed as smokers in ciency was issued at y (IJ) level as R23 remained t injury or death related to	Fé	\$89	1.It is the policy of this facility to abide the 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 we 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	of as , /ith

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				יחיד		<u>//B NO.</u>	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245231	B. WING			06/3	30/2021
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON AREA HEALTH			-	0 S BEHL ST APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 689	oxygen was observ cigarettes in conjun- rapidly accelerate of in significant injury and visitors in the a Director of Nursing immediate jeopardy immediate jeopardy 1:38 p.m. but non-o	ge 27 red to be turned on. Smoking action with using oxygen can combustion. This could result or death to the residents, staff, area. The Administrator and (DON) were notified of the y at 1:36 p.m. on 6/29/21. The y was removed on 6/30/21, at compliance remained at an severity which indicated no	F 6	89	residents, R23 provider was notified incident, 2.All residents, visitors, or staff with feet of oxygen in use with a combus are potentially affected. 3.Smoking policy was revised to ad no oxygen use during smoking. Staff-Education initiated on 6/29/21 included: no oxygen equipment on/o including resident □s wearing nasal	in 15 stible dress that	
	actual harm with po harm (Level D). Findings include: R23's quarterly Min 4/28/21, included R Mental Status (BIM indicating R23 was required extensive daily living, locomo	imum Data Set (MDS) dated 23 had a Brief Interview for S) score of 13 out of 15, cognitively intact. R23 assistance with activities of tion via wheelchair, and was en. The quarterly MDS lacked			cannula/mask should not be within flames including cigarette products, lighters/vape pens, residents that sr requires a smoking assessment wit changes in condition to include functionality, initiation of oxygen and changes in oxygen therapy and edu on following resident □s plan of care Education added to new employee orientation. 4.DON/ Designee will complete aud residents that smoke for changes in	moke h d/or ication e.	
	documentation of F face sheet identifier respiratory failure, I obstructive pulmon R23's care plan rev had limited physica and was dependen to and from all dest continuous oxygen breath with exertior plan indicated R23 known. The smokir indicated R23 smol and was O2 depen- listed R23 would sm	R23's tobacco status. R23's d diagnoses included neart failure, and chronic			condition/functionality & oxygen the initiation in clinical meeting weekly v end date. The resident that require supervision has been randomly aud which was initiated on 7/1/21 to ens staff compliance with policy and res care plan that oxygen be left in her Audits will continue twice weekly x4 monthly x2. Results of the audits wi submitted to the QA committee for evaluation and updates.	rapy with no lited, sure ident room. then	

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		AND HUMAN SERVICES & MEDICAID SERVICES				PRINTED: 0 FORMAN OMB NO. 0	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:			ì í			(X3) DATE SURVEY COMPLETED	
	245231					06/:	30/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON AREA HEALTH				30 S BEHL ST APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	staff were to assist ensure O2 was turn cannula prior to R22 returning to residen apply nasal cannula on. The care plan ic extinguish her own and cigarettes on se R23's Smoking Saf 4/28/21, at 3:20 p.m cognitive loss, visua problems. The asse capable of lighting f assistance getting t and did not need th and cigarettes. A no "IDT [interdisciplina A/O [alert and orien light cigarette on ow cigarette. Understat allowed. Needs ass designated smoking be off when smokin the assessment rea Staff will escort the Turn off oxygen. Wi to alert staff when y turn O2 back on. St Has compact O2 at not to use when smoking provider orders data liters per minute, per	a revised 2/11/21, included R23 to smoking location, ned off, and remove the nasal 3 lighting a cigarette. Upon t, staff were to immediately a and turn the O2 concentrator dentified R23 could light and cigarettes, and keep lighter elf. ety Screen assessment dated n. indicated R23 had no al deficits, or dexterity essment indicated R23 was ner own cigarette, required o and from the smoking area, e facility to store her lighter ote on the assessment read, ry team] feel the resident is ited], cognitively intact. Able to wn. Can control ashes from nds location where smoking is sistance to get to/from g area. Understands O2 must ig." Conditions also included in ad, "Will request to smoke. resident to the smoking area. ill use Walkie Talkie or phone would like to come in. Staff will caff escort back into building. ole to apply per self, aware of noking."	Fθ	\$89			

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		AND HUMAN SERVICES				FORM	08/05/2021 APPROVED 0938-0391	
STATEMENT	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA LAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED		
		245231	B. WING			06/30/2021		
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
APPLET	ON AREA HEALTH				30 S BEHL ST APPLETON, MN 56208			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 689	During observation was in her room, sin holes or heat dama When interviewed of stated she smoked occasionally went of sit while using oxyg portable O2 concert when she smoked, she put out her cigat cigarettes and light to transport her to t unable to move her During interview on nursing assistant (N smoked was asses safe. She stated R2 designated smoking independently. NA- was powered on un area. Once there, s removed the nasal on the back of the r stated residents we for staff assistance smoking area. During observation was smoking in the a nasal cannula in the concentrator was o resident's left side. right hand. R23 pla- cigarette receptacle immediately turned with her left hand. F	nge 29 on 6/28/21, at 5:57 p.m. R23 tting in wheelchair. No burn nge were noted on her clothing. on 6/28/21, at 5:58 p.m. R23 at least once per day, but but to the smoking area just to pen. R23 stated she took her narater. She stated she kept her er with her, turned it off and turned it back on after arette. She stated she kept her er with her, but relied on staff he smoking area as she was wheelchair independently. 6/29/21, at 9:44 a.m. certified NA)-F stated anyone who sed to make sure they were 23 needed help to get to the g area but could smoke F stated the O2 concentrator ttil R23 arrived at the smoking staff turned off the O2, cannula, and hung the tubing resident's wheel chair. She ere given a 'walkie' and called when they wanted to leave the 6/29/21, at 10:28 a.m. R23 designated smoking area with her nose. R23's oxygen ff and placed on a chair to the R23 had a lit cigarette in her ced her cigarette in the e with her right hand and on the oxygen concentrator R23 remained in the g area with another resident	F	589				

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		AND HUMAN SERVICES				FORM	08/05/2021 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE	E SURVEY PLETED	
		245231	B. WING	i		06/30/2021		
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
APPLET	ON AREA HEALTH				30 S BEHL ST APPLETON, MN 56208			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 689	who was smoking w oxygen concentrator resident and a visitor smoking. During a subsequent 10:49 a.m. director registered nurse (R smoking area. R23 hand. Her oxygen of indicated by the dig oxygen tubing was cannula was in R23 approximately 5 fee The two residents w confirmed the conc immediately turned immediately turned immediately turned immediately turned immediately turned immediate education when wearing O2 w requested R23 rem however R23 refuse smoking materials f R23 stated she was her nasal cannula w placed her cigarette DON's offer to trans called for alternate the building. R23 re and RN-B until 10:5 NA-G returned R23 When interviewed of stated wearing O2 w unacceptable. Her or removed the nasal stated her preferen brought to the smoli confirmed R23 was	within six feet of R23 and the or. There was one other or also present, neither were and observation on 6/29/21, at of nursing (DON) and N)-B were brought to the had a lit cigarette in her right concentrator was turned on as ital display on the unit. The connected to the unit and the B's nose. Another resident sat et from R23 with a lit cigarette. were facing each other. DON entrator was turned on and it off. DON provided on to R23 regarding smoking was a safety hazard. DON hove the nasal cannula, ed. DON requested all from R23 but R23 refused. Is not previously told to remove when smoking. R23 then e in the receptacle, refused sport her into the facility, and assistance to go back into to emained supervised by DON 53 a.m. when NA-G arrived. B to her room at 10:57 a.m.	F	589				

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CENTERS FOR MEDICARE & MEDICAID SERVICES       OMB NO. 0938-033         STATEMENT OF DEFICIENCIES       (X1) PROVIDERSUPPLIER       (X2) MULTIPLE CONSTRUCTION         AND PLAN OF CORRECTION       (X1) PROVIDER OR SUPPLIER       (X2) MULTIPLE CONSTRUCTION         APPLETON AREA HEALTH       245231       B. WING       06/30/2021         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       30 S BEHL ST         APPLETON AREA HEALTH       SUMMARY STATEMENT OF DEFICIENCIES       PROVIDER OR SHOP PLAN OF CORRECTION MOUNT BE FREGEDED BY FULL         PREFIX       REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX       PROVIDER OR SHOULD BE       COSS-REFECTION         F 689       Continued From page 31       F 689       F 689       F 689       Continued From page 31       F 689         agreed to remove the Q2 cannula when going out to smoke, but still requested the oxygen concentrator remain with her when she went to smoke, but still requested the oxygen concentrator remain with her when she went to smoke, but still requested the oxygen 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 dindri realize untill she had taken two pulfs. Reviewed smoking policy with resident and another nurse present. Explained to resident that plan would now change and she would have supervision with smoking area. Resident to be anothing area. Resident became upset, raising voice at nurse stating. Wheil keil do f prison shit			AND HUMAN SERVICES				FORM	08/05/2021 APPROVED
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         APPLETON AREA HEALTH       30 8 BEHL ST APPLETON, MN 56208         YA() ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED B Y FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETIC DATE         F 689       Continued From page 31 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 R22 needed to be reassessed with new interventions placed for safety.       F 689         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 untill 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 outsjide to smoking area. Resident became upset, raising voice at nurse	STATEMENT	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	ì í		E CONSTRUCTION	(X3) DAT	E SURVEY
30 S BEHL ST APPLETON AREA HEALTH       (xi) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH DECRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     (xi) PREFIX TAG     PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     (xi) DEFICIENCY       F 689     Continued From page 31 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.     F 689       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 dich'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			245231	B. WING	i		06/	30/2021
APPLETON AREA HEALTH       APPLETON, MN 56208         (x) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIDT BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MIDD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       000         F 689       Continued From page 31 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.       F 689         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 it 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 it 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	NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PRÉFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PRÉFIX TAG       CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE       COMPLÉTIC DATE         F 689       Continued From page 31 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.       F 689       F         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	APPLET	ON AREA HEALTH						
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 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	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	COMPLETION
<ul> <li>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."</li> <li>The facility Smoking Policy last revised 7/18 with expiration of 7/19 outlined expectations for patients, tenants, visitors, and employees. The</li> </ul>	F 689	agreed to remove the safety of the safety. R23's progress note identified, "Reporter outside in the design with surveyor and so oxygen on. Resider she was tearful staticigarette and turner outside visiting. She was on and lit a cign she had taken two policy with resident Explained to reside and she would have and that smoking sinurse's desk. Oxyg would not be taken Resident became ustating, What kind of my cigarettes from explosion, and possit has been done in telling staff that the did calm down with and four cigarettes. anymore in her room."	he O2 cannula when going out equested the oxygen n with her when she went to d R23 needed to be ew interventions placed for e dated 6/29/21, at 11:18 a.m. d by staff that resident was gnated smoking area visiting she lit a cigarette while she had nt interviewed in her room and ting she had finished her d her oxygen on while still e states she forgot the oxygen larette and didn't realize until puffs. Reviewed smoking and another nurse present. ent that plan would now change e supervision with smoking upplies would be kept at the len concentrator and tubing outside to smoking area. upset, raising voice at nurse of prison is this!' 'You can't take me!' Risk for injury, burns, sible death explained to her as the past. Resident crying and y are abusing her. Resident 1:1 and gave nurse her lighter . Stated she did not have m. Staff updated on new dent will be supervised with ator and tubing will be left in	F	389			

Facility ID: 00655

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		AND HUMAN SERVICES				FORM	08/05/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245231	B. WING			06/;	30/2021
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON AREA HEALTH				0 S BEHL ST PPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	policy identified the visitors and long ter were in the LTC cer side near the kitche end of the west par dumpster, and on th under the shade tree for safe smoking as any requirement to smoking. No addition related to smoking smoking were prov The Smoking Safet 11:47 a.m. identified smoke with supervit assistance. The fact and cigarettes. During continuous of 12:52 p.m. R23 put entered R23's room cannula and concer then pushed R23 to checked R23's oxy a bag containing R2 the medication room transported R23 to where R23 smokeo NA-K. -At 1:03 p.m. NA-K -At 1:12 p.m. R23 p receptacle and required NA-F transported R checked R23's O2 bag with R23's light medication room, a where NA-F placed	designated smoking areas for rm care (LTC) center residents inter parking lot on the west en entrance, and on the South king lot near the street or he west end of the parking lot ee. The policy lacked direction assessment, and further lacked remove oxygen prior to onal policies or procedures safety or unsupervised	F 6	89			

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		AND HUMAN SERVICES				FORM	08/05/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í			(X3) DATI	E SURVEY PLETED
		245231	B. WING			06/	30/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
APPLET	ON AREA HEALTH				30 S BEHL ST APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 689	without staff superv	-	F	689			
	was removed on 6/ was verified, based that the facility succ	30/21, at 1:38 p.m. when it on observation and interview cessfully implemented a included the following:					
	requirement -Removal of R23's concentrator prior to designated smoking -Facility storage of	B's smoking supervision nasal cannula and oxygen o transportation to the g area R23's cigarettes and lighter D2 saturation levels both					
	-All cigarettes and I R23's possession. I regarding the risk o care plan was upda nasal cannula will r smoking.	ighters were removed from R23 was re-educated of smoking with oxygen, and ated to reflect oxygen and emain in R23's room while smoked, including R23, were					
	adequacy and upda will have a smoking initiation of smoking and any changes of functionality. Educa should be addresse documented. Smok source of ignition sl (4.3 meters) away f atmosphere such a via nasal cannula, o	g policy was reviewed for ated to include LTC residents g assessment on admission, g after admission, quarterly, f condition which include ation on smoking cessation ed with each assessment and king materials and any other hould be kept at least 15 feet from an oxygen-enriched is a resident receiving oxygen oxygen mask or other delivery materials will be stored in the					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/05/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245231	B. WING			06/30/2021	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON AREA HEALTH				0 S BEHL ST APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689 F 732 SS=C	oxygen. Oxygen, na remain in the reside the designated smor require supervision to the smoking area for the duration of th without the dexterity prohibited from smor supervision or indep smoking assessme and updated when reserves the right to is imminent threat th Posted Nurse Staffi CFR(s): 483.35(g)(1) §483.35(g) Nurse S §483.35(g)(1) Data must post the follow basis: (i) Facility name. (ii) The total numbe by the following cate unlicensed nursing resident care per sh (A) Registered nurse (B) Licensed practio vocational nurses (a (C) Certified nurse a (iv) Resident censu §483.35(g)(2) Posti (i) The facility must specified in paragra	r residents who require asal cannula and mask will ent's room while smoking in oking area. Residents who will be accompanied by staff a and remain with the resident he smoke break. Residents y to hold a cigarette will be oking. The need for bendent will be reflected in the nt, addressed in the care plan, indicated. The care center o prohibit smoking when there o patient safety. ng Information 1)-(4) staffing Information. requirements. The facility ving information on a daily e. er and the actual hours worked egories of licensed and staff directly responsible for hift: ses. cal nurses or licensed as defined under State law). aides. s. ng requirements. post the nurse staffing data uph (g)(1) of this section on a eginning of each shift.	F 6				8/4/21

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		<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MILLIT	TIPLE CONSTRUCTION		0938-039 E SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		NG		PLETED
		245231	B. WING_		06/3	30/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
APPLET	ON AREA HEALTH			30 S BEHL ST APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 732	Continued From pa	ge 35	F 73	32		
	<ul><li>(A) Clear and reada</li><li>(B) In a prominent presidents and visitor</li></ul>	place readily accessible to				
	staffing data. The f written request, ma	c access to posted nurse facility must, upon oral or ke nurse staffing data lic for review at a cost not to nity standard.				
	posted daily nurse 18 months, or as re is greater.	facility must maintain the staffing data for a minimum of equired by State law, whichever				
	by: Based on observat review, the facility f staffing information location. This had t	NT is not met as evidenced tion, interview, and document ailed to post daily nurse in an easily accessible he potential to effect all 43 heir families, and visitors.		1.It is the policy of this fa state and federal regulati nursing staff data in a pro readily accessible. The re information was posted of	ons by posting ominent place equired staffing	
	Findings include:			speaking with the survey 2.All residents, family me guardians and visitors are	or. mbers, legal	
	staffing representat was located on a cl station. She presen sheet but was not a	06/30/21, at 10:51 a.m. the tive stated the staff posting ipboard behind the nurse's ited the daily assignment aware of any posting for luded staff times and census.		affected by the cited defic 3.To enhance the Care C and under the direction o Nursing or designee, the receive an in-service on p required staffing informat 4.Director of Nursing or c	ciency. enter operations f the Director of nursing staff will posting the ion daily.	
		on 6/30/21, at 10:52 a.m. the vall to the right of the ADON pty.		staff posting daily x7 for 2 x4, then monthly x2. Res will be reported to the QA review and action, as app	2 weeks, weekly sults of the audits a committee for	
	licensed practical n	6/30/21, at 10:52 a.m. urse (LPN)-B stated the staff e been on a cork board on the		committee will determine further audits and/or action	the need for	

Facility ID: 00655

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		AND HUMAN SERVICES				FORM	08/05/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		245231	B. WING _			06/:	30/2021
NAME OF I	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON AREA HEALTH				) S BEHL ST PPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 732 F 761 SS=D	wall to the right of the (ADON) office above was not there, and done by the night sto of nursing (DON). It something posted the attention to it. During interview on stated she did not ke was. She stated it we information in an ear residents knew who DON acknowledged not posted and individed accessibility due the Label/Store Drugs a CFR(s): 483.45(g)(I §483.45(g) Labeling Drugs and biological labeled in accordant professional princip appropriate access instructions, and the applicable. §483.45(h) Storage §483.45(h)(1) In acc Federal laws, the far biologicals in locked temperature contro personnel to have a §483.45(h)(2) The filocked, permanent	he assistant director of nursing we a sofa. She acknowledge it stated it should have been taff, the ADON, or the director She stated there was always here but she had not paid 6/30/21, at 11:01 a.m. DON show where the staff posting was important to provide this asily accessible place so to was assigned to them. The d the staffing information was cated concern over lack of e sofa underneath. and Biologicals h)(1)(2) g of Drugs and Biologicals als used in the facility must be nee with currently accepted bles, and include the ory and cautionary e expiration date when a of Drugs and Biologicals cordance with State and acility must store all drugs and d compartments under proper ls, and permit only authorized	F 75				8/4/21

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	RS FOR MEDICARE	& MEDICAID SERVICES	(X2) MUUTU		IB NO. 0938-039 X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G	COMPLETED
		245231	B. WING		06/30/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
APPLET	ON AREA HEALTH			30 S BEHL ST APPLETON, MN 56208	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 761	the Comprehensive Control Act of 1976 abuse, except when package drug distri quantity stored is m be readily detected This REQUIREMED by: Based on observat review the facility fa available for use in appropriately labele 2 medication carts storage. Findings include: R40's face sheet da diagnosis included R40's medication a 6/1/21-6/30/21, indi eye drop, Azopt Su times daily for glaud On 6/29/21 at 4:35 (LPN)-A and survey Suspension 1% we was no opened dat on the medication to pharmacy label, thi 5/28/21. On 6/29/21, during LPN-A stated it was is written on the ph bottles are first open	e Drug Abuse Prevention and and other drugs subject to in the facility uses single unit ibution systems in which the ninimal and a missing dose can NT is not met as evidenced tion, interview, and document ailed to ensure medications a medication cart were ed with an opened date in 2 of reviewed for medication ated 6/30/21, indicated R40's dementia and glaucoma.	F 76	<ol> <li>1.It is the policy of this facility to abid state and federal regulations related storage of drugs and biologicals. A complete audit was completed on bo medication carts; eye drops without open date was discarded and reorde R40 was not negatively impacted by cited deficiency.</li> <li>2.All residents receiving eye drops a potentially affected by the cited defic 3.To enhance the Care Center clinic practice and under the direction of th Director of Nursing or designee, an in-service will be completed with lice nurses and TMA□s on applying an of date for eye drops. Use after open d should not exceed 28 days and risk associated with exceeding 28 days.</li> <li>4.Director of Nursing or designee wi medication cart weekly x4, then mor x3. Results of the audits will be repor to the QA committee for review and action, as appropriate. The QA commit will determine the need for further at and/or action plan.</li> </ol>	to bth an ered. the re siency. al ne onse open ate Il audit nthly orted mittee

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/05/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245231	B. WING			06/:	30/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON AREA HEALTH				30 S BEHL ST APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	administered after t certain what the exp for Azopt but though for 28 days after the confirmed there we Azopt solution 1% for On 6/30/21, at 3:32 (PC)-A indicated ey when opened. The increased the longe was opened. There infection if the eye of expiration date. PC- should be stopped in they are opened. On 6/30/21, at 2:00	hat date. LPN-A was not biration date after opening was nt most eye drops were good ey were opened. LPN-A re no other opened bottles of or R40. p.m. pharmacy consultant e drops needed to be dated risk of bacterial growth er the bottle was used after it was an increased risk of drop was used after the -A stated Azopt eye drops no more than 28 days after p.m. director of nurse (DON)	F7	761			
	when opened. Unla unacceptable. Facility policy, Labe last revised 7/2019, label should include applicable, but did r eye drops with the of Food Procurement, CFR(s): 483.60(i)(1 §483.60(i) Food saf The facility must - §483.60(i)(1) - Proc approved or conside state or local author (i) This may include	Store/Prepare/Serve-Sanitary )(2) Tety requirements. Sure food from sources ered satisfactory by federal,	F٤	312			8/4/21

Facility ID: 00655

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				FORM	08/05/2021 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY PLETED
	245231	B. WING		06/3	30/2021
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
APPLETON AREA HEALTH			30 S BEHL ST APPLETON, MN 56208		
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFI TAG		BE	(X5) COMPLETION DATE
<ul> <li>facilities from using pr gardens, subject to co safe growing and food (iii) This provision doe from consuming foods</li> <li>§483.60(i)(2) - Store, serve food in accorda standards for food ser This REQUIREMENT by: Based on observation review the facility faile the kitchen were prop dust which had the po residents in the facility</li> <li>Findings include: During observation on thick dust/debris was oscillating fan that was steam table and prep</li> <li>During interview on 6/ stated it was not sanit is not sure who cleans</li> <li>During interview on 6/ rep (assisting with die stated that she sees a and further stated it w blowing in the kitchen sanitary to be blowing areas. Staffing rep sta cleans the fan as she</li> </ul>	ulations. Is not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices. Is not preclude residents s not procured by the facility. prepare, distribute and ance with professional rvice safety. is not met as evidenced n, interview, and document ed to make sure the fans in perly cleaned and free of otential to affect all 43 y. n 6/28/21, at 10:29 a.m. observed on black is blowing towards the counters. /28/21, at 10:29 a.m. cook-A tary to have dust on fan, she s it. /28/21, at 10:52 a.m. staffing etary) observed the fan and a lot of lint/debris on the fan vas not ok for that fan to be a as it is a fire hazard and not g the dust onto the serving ated she was unsure who	Fε	<ul> <li>1.It is the policy of this facility to all state and federal regulations relate food safety. The black oscillating faremoved from the kitchen after spewith surveyor.</li> <li>2.All residents, family members, le guardians and staff that consume f from the kitchen are potentially affet the cited deficiency.</li> <li>3.To enhance the Care Center pradand under the direction of the Dieta Manager or designee, dietary staff receive an in-service on 7/30/21 er equipment is thoroughly cleaned af each use.</li> <li>4.Dietary Manager or designee will randomly audit kitchen equipment 'x4 then monthly x3. Results of the will be reported to the QA committer review and action, as appropriate. committee will determine the need further audits and/or action plan.</li> </ul>	d to an was eaking gal ood ected by ctices ary will suring fter weekly audits ee for The QA	

Facility ID: 00655

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		AND HUMAN SERVICES				FORM	08/05/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245231	B. WING			06/3	30/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON AREA HEALTH				0 S BEHL ST PPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	Continued From pa	ge 40	F٤	312			
	dietician stated it is	6/29/21, at 4:08 a.m. the not acceptable to have a fan dust in the kitchen, as it the food sources.					
	revised 9/2016, indi and control contam infection within the	n and control (Dietary) policy icated the purpose "To prevent ination and the spread of dietary department" "All thoroughly cleaned after each					
F 880 SS=F			F 8	380			7/30/21
	infection prevention designed to provide comfortable enviror	tablish and maintain an and control program a safe, sanitary and ment and to help prevent the ransmission of communicable					
	program. The facility must es	n prevention and control tablish an infection prevention n (IPCP) that must include, at owing elements:					
	reporting, investigat and communicable staff, volunteers, vis providing services u arrangement based	l upon the facility assessment ig to §483.70(e) and following					

Facility ID: 00655

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		AND HUMAN SERVICES & MEDICAID SERVICES						FORM	08/05/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			E CONSTRUCTION		(X3) DATE	E SURVEY PLETED
		245231	B. WING	i				06/3	30/2021
NAME OF F	PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CO	DDE		
APPLET	ON AREA HEALTH					) S BEHL ST PPLETON, MN 56208			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG			PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 880	§483.80(a)(2) Writte procedures for the p but are not limited t (i) A system of surve possible communic infections before the persons in the facili (ii) When and to wh communicable dise reported; (iii) Standard and tr to be followed to pre (iv)When and how i resident; including t (A) The type and du depending upon the involved, and (B) A requirement the least restrictive pos circumstances. (v) The circumstance must prohibit emplo disease or infected contact with resider contact will transmit (vi)The hand hygier by staff involved in o §483.80(a)(4) A sys- identified under the corrective actions ta §483.80(e) Linens. Personnel must har	en standards, policies, and program, which must include, o: eillance designed to identify able diseases or ey can spread to other ty; oom possible incidents of ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a but not limited to: uration of the isolation, e infectious agent or organism hat the isolation should be the sible for the resident under the ces under which the facility by es with a communicable skin lesions from direct t the disease; and he procedures to be followed direct resident contact. etem for recording incidents facility's IPCP and the aken by the facility.	F٤	880	0				

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	OF DEFICIENCIES	<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPLE CONSTRUCTION		<u>). 0938-039</u> .te survey		
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,			MPLETED		
		245231	B. WING		06	6/30/2021		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CIT	Y, STATE, ZIP CODE			
APPLET	ON AREA HEALTH			30 S BEHL ST APPLETON, MN 56	6208			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORR	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE		
F 880	Continued From pa	ge 42	F 8	80				
	IPCP and update the This REQUIREMENT by:	duct an annual review of its heir program, as necessary. NT is not met as evidenced tion and interview, the facility		1.It is the policy	y of this facility to abide by			
	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.			state and federa maintain an infe control program and comfortable prevent the dev transmission of and infections.	al regulations related to action prevention and n designed a safe, sanitary e environment and to help	/,		
	Findings include:			and after admin resident, before gloves, and me	istering medication to a and after removal of dications should not be			
	indicated R5 had m and was usually ab	a Set (MDS) dated 3/24/21, oderate cognitive impairment le to understand others. R5's Parkinson's, Schizoaffective ar.		staff was provid shields on 6/30/ was not negativ deficiencies	are hands. In addition, all led surgical mask and eye /21. No resident nor R5 rely affected by the cited nave to the potential to be			
	observation, TMA-A the medication cart medications to ano	p.m. during medication pass A was observed returning to after administering oral ther resident, she did not wash and sanitizer upon returning to		to hand hygiene equipment (PPI 3.To enhance th	cited deficiencies related and personal protective E). The Care Center infection and under the direction c	f		
	the medication cart mouse to documen medications and to medications. She th	. TMA-A used the computer t administration of those look up R5's scheduled nen removed keys from her		the Director of N Preventionist, th completed an R identified cause	Nursing, and Infection ne interdisciplinary team RCA on 7/20/21 that e of the cited deficiencies.			
	pocket. TMA-A ope then removed three	en returned the keys to her ned the medication drawer e cards containing oral		revised on 7/22 was developed	e policy was reviewed and /21, a policy & procedure and implemented for			
	them on the top of t top drawer of the m	ne medication cart and placed the cart. She then opened the redication cart and removed placed it on the top of the cart.		eye protection b b.All Care Cent	and policy & procedure for based on risk assessment er staff that may enter a n or encounter a resident			

Facility ID: 00655

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STATEMEN	OF DEFICIENCIES	KOMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY PLETED	
		245231	B. WING				
	PROVIDER OR SUPPLIER	245251	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	06/	30/2021	
	ON AREA HEALTH			30 S BEHL ST APPLETON, MN 56208			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE	
F 880	it on the top of the ingrabbed the top mediand, placing her let then pushed the or and into the palm of then placed the median of the near the placed the median of the three medication locked the medication cup. The medications and the inhaler were brough on 6/29/21, at 5:28 automatic that she had pills out into her hands returning to the medication cup, no Facility policy for hap ass was requested preE On 6/28/21, at 5:15 was observed weat to the	stic medication cup and placed medication cart. TMA-A edication card in her right eff hand under the card. She al medication through the card of her ungloved left hand. She edication in the medication cup repeated this action with the ications. TMA-A then returned on cards to the drawer and ion cart. She used the mouse er screen. TMA-A then used a sauce into another plastic ne two cups, with the oral e applesauce, and the oral ht into R5's room. B p.m. TMA stated it is punched the oral medications on card and into her ungloved never been told to not punch nd. TMA-A confirmed she did s or use hand sanitizer when	F 88	within the facility will be in-service hand hygiene, standard infection practices, transmission based- precautions, and appropriate PF Understanding & retention of the will be validated and documente competency and demonstration. addition, TMAs will have direct observation with medication administration following hand hy training by a license nurse. 4.Director of Nursing, Infection Preventionist or designee will au hygiene & proper PPE use all sh everyday x 1 week, once 100% compliance is achieved audits w decrease to all shifts 5 days per then all shifts twice per week x4 each shift monthly x2. Results of audits will be reported to the QA committee for review and action appropriate. The QA committee determine the need for further a and/or action plan.	control E use. material d with In giene dit hand ifts ill week x2, then f the as will		

If continuation sheet Page 44 of 52

		AND HUMAN SERVICES				FORM	08/05/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245231	B. WING			06/:	30/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
APPLET	ON AREA HEALTH				30 S BEHL ST APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	During interview NA currently had on is a since he started ap NA-D indicated no of able to wear a cloth several other staff a NA-D provided assist cloth mask after ea confirmed he worked and provided perso throughout each sh each unit of the fac mask. On 6/29/21, at 10:2 (HSKP)-A stated cloth because the risk ar HSKP-A was not su was, "I think they ar stated there was not put out regarding the assumed that cloth On 6/29/21, at 1:56 wearing a cloth face washes the face ma NA-E was not sure able to filter out and removable/changea NA-E indicated no of wear a surgical mas fine with us having confirmed he had s him, but he preferre was thicker. NA-E of units within the facil	Inge 44 Ing face-to-face with residents. A-D stated the cloth mask he the one he has been using proximately two months prior. One had told him he was not a masks and he had seen also wearing cloth masks. Urance that he is washing the ch shift he works. NA-D ed with a variety or residents and cares several times iff worked. He has worked ility, while wearing the cloth 5 a.m. housekeeping oth masks are allowed now e low enough in the county. Ure what the actual number re just allowing it." HSKP-A o communication or training he face masks, but it was face masks were allowed. p.m. NA-E was observed e mask. NA-E stated he ask, "every now and then." what the cloth face mask was d confirmed there was not a able filter inside the mask. One had told him he needed to sk, "as far as I know they are these masks on." NA-E urgical masks available to ed the cloth mask because it confirmed he has worked all lity and has provided care to luded assisting with a variety	Fδ	80			

If continuation sheet Page 45 of 52

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		E SURVEY PLETED
		245231	B. WING			06/:	30/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON AREA HEALTH				0 S BEHL ST VPPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	REGULATORY OR LA Continued From pa On 6/29/21, at 2:01 was interviewed ab with person cares w RN-C responded, "t covering. They do w staff were required cloth masks. RN-C currently experience protective equipment masks. RN-C confit facility document, C update, dated 6/15/ must wear a well-fit when working in co sure what source the also confirmed a line document to a Minne website. COVID-19 Recomment Workers, dated 5/1 and fully vaccinated should continue to w facemask and eye source control. On 6/28/21, at 4:12 was observed at nut	SC IDENTIFYING INFORMATION)			CROSS-REFERENCED TO THE APPROPR		
	wearing a cloth may protection nor had i On 6/29/21, at 9:05	sk. Neither wore eye					

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PRINTED: 08/05/2021

		AND HUMAN SERVICES				FORM	08/05/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245231	B. WING			06/	30/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON AREA HEALTH				0 S BEHL ST VPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	Continued From pa observed	ge 46	F 8	80			
	stated the need for was based on the c facility communicate mass text. She stat quarantine she wou otherwise a surgica	6/29/21, at 9:06 a.m. NA -B personal protective equipment county positivity rate, and the ed the information to staff via red if a resident was in ald wear an N95 mask, al mask was required. She on was not required.					
	(AS)-A was observe	6 a.m. activities staff member ed wearing a floral disposable on was neither worn nor on her					
	stated she ordered preferred them as t stated there was no residents were vaco	6/29/21, 09:26 a.m. AS-A her masks online and hey were not as 'fibery'. She o way to know which staff or cinated therefore all were me standard precautions.					
		a.m. NA-F was observed mask. Eye protection was her person.					
	stated the facility pr	6/29/21, at 09:44 a.m. NA-F ovided masks for staff, but red to wear eye protection.					
	wearing a mask cov	0 p.m. NA-G was observed vering only his mouth. Eye her worn nor on his person.					
	stated he used to w was COVID-19, but	6/29/21, at 12:50 p.m. NA-G year eye protection when there t stated it was now optional. was allowed to wear his mask					

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		AND HUMAN SERVICES				FORM	08/05/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245231	B. WING			06/:	30/2021
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON AREA HEALTH				0 S BEHL ST APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	under his nose whe he was vaccinated evidenced by a red stated if staff are var masks when around During observation was at the nursing s Eye protection was person. Two boxes protection were avar nursing station. During observation was wearing a cloth neither worn nor on During observation TMA-B was not wea on her person. During interview on preventionist RN-C their name badge w unvaccinated staff s protection. He state wear the tag, but m He stated he would staff must wear sur home made or cloth know if the floral dis but the facility had p During interview on preventionist RN-C county had a mode	en not with a resident because against COVID-19, as tag on his name badge. He accinated they can remove d other vaccinated staff. on 6/30/21, at 7:32 a.m. NA-J station wearing a cloth mask. neither worn nor on her of masks and one box of eye ailable on the counter at the on 6/30/21, at 7:33 a.m. DON n mask. Eye protection was her person. on 6/30/21, at 7:35 a.m. aring eye protection, nor was it 6/29/21, at 2:34 p.m. infection stated staff with a red tag on vere vaccinated, and should have been wearing eye ed he could not require them to toost vaccinated staff wore it. I change the policy to indicate gical masks and cannot wear h masks. He stated he did not sposable masks were surgical, plenty of masks for staff.	Fε	880			

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIDI 🖬	CONSTRUCTION	א ח (צצ)	TE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	• •			MPLETED	
		245231	B. WING		06/30/2021		
NAME OF F	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CC	DE		
APPLET	ON AREA HEALTH		30 S BEHL ST APPLETON, MN 56208				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 880	Continued From pa	age 48	F 880				
F 883 SS=D	eye protection as o Department of Hea Universal Eye Prote Long-term Care an dated 6/25/21.	meet the criteria to remove utlined in the Minnesota lth guidance COVID-19 ection Risk Assessment for d Assisted Living-type Settings mococcal Immunizations 1)(2)	F 883			8/4/21	
	immunizations §483.80(d)(1) Influe policies and proced (i) Before offering the each resident or the receives education potential side effect (ii) Each resident is immunization Octol annually, unless the contraindicated or the immunized during the (iii) The resident or has the opportunity (iv)The resident's in documentation that following: (A) That the resident was provided education and potential side efficient (B) That the resident immunization or disc	the resident's representative to refuse immunization; and nedical record includes t indicates, at a minimum, the nt or resident's representative ation regarding the benefits					

ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	DIE CONSTRUCTION	X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G	COMPLETED
		245231	B. WING		06/30/2021
IAME OF F	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE	
PPLET	ON AREA HEALTH			30 S BEHL ST APPLETON, MN 56208	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 883	Continued From pa that-	ge 49	F 88	3	
	<ul> <li>(i) Before offering the immunization, each representative receipts and potent immunization;</li> <li>(ii) Each resident is immunization, unlease medically contrained already been immunization already been immunization that the opportunity (iv) The resident or has the opportunity (iv) The resident's medicumentation that following:</li> <li>(A) That the resider each and potential side each and potential side each munization; and</li> <li>(B) That the resider pneumococcal immunication or following:</li> </ul>	a resident or the resident's ives education regarding the ial side effects of the offered a pneumococcal so the immunization is icated or the resident has nized; the resident's representative to refuse immunization; and nedical record includes indicates, at a minimum, the ation regarding the benefits offects of pneumococcal int either received the nunization or did not receive immunization due to medical			
	by: Based on interview facility failed to offe pneumococcal vace the Centers for Dise residents (R23, R30 vaccinations. Findings include: The CDC guideline Timing for Adults, d persons with medic	<i>i</i> and document review, the		1.It is the policy of this facility to abid state and federal regulations related influenza and pneumococcal vaccine specifically ensuring residents if med indicated can receive the pneumococ vaccine when indicated based upon previous vaccination and/or diagnosi R23 was not negatively impacted by cited deficiency and received the pneumococcal vaccine on 7/14/21. 2.A total census audit was completed 7/9/21. A total of 11 residents were identified to receive the pneumococc	e, lically ccal age, is. the d on

Facility ID: 00655

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		<u>&amp; MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	IPI F			0938-039 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				COMPLETED	
		245231	B. WING			06/30/2021	
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	DE	
APPLET	ON AREA HEALTH		30 S BEHL ST APPLETON, MN 56208				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIO DATE
F 883	should be given eit 1) a second dose a after the first dose 2) a dose of PCV13 one year after the F dose of PPSV23 at PCV13 and at leas dose of PPSV23. The guidelines furth a dose of PCV13 o PPSV23 at least or R23's quarterly Mir 4/28/21, indicated F with diagnoses of of failure, high blood p was age 66. The M cognitively intact, a vaccination was no facility indicated on offered and decline R23's facility Immu indicated R23 rece 11/17/2012 at the a for either 1) a seco dose of PCV13. R23's medical reco screening, educatio or refusal for either vaccination. R36's quarterly MD R36 was first admit including diabetes, R36's was age 72.	her: after age 65 at least five years if PCV13 is not given, or 3 at age 65 or older at least PPSV23, followed by a final t least one year after the t 5 years after the most recent her indicated for persons given wer the age of 65, then give he year after PCV13. himum Data Set (MDS)dated R23 was re-admitted 4/2/21, chronic lung disease, heart pressure, and anemia. R23's IDS also identified R23 was ind R23's pneumococcal it up to date, however the the MDS the vaccine was	F 88	33	documented in the medical record 3.To enhance the Care Center infe control program and under the dire the Director of Nursing or designee license nurses were in-service on pneumococcal vaccine and the po indicating residents will be assess eligibility to receive the pneumococ vaccine series, and when indicated offered the vaccine within 30 days admission to the facility unless me contraindicated. 4.Director of Nursing or designee v immunization records monthly x 6. Results of the audits will be reporte the QA committee for review and a as appropriate. The QA committee determine the need for further aud and/or action plan.	ection ection of e, licy ed for ccal d will be of dically will audit ed to action, e will	

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		AND HUMAN SERVICES				FORM	): 08/05/2021 APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245231	B. WING	i		06	/30/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
APPLET	ON AREA HEALTH				30 S BEHL ST APPLETON, MN 56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 883	Continued From pa	ige 51	F {	383	3		
	pneumococcal imm to date.	nunization was marked as up					
	indicated R36 recei	nization Record date 6/30/21, ived the PCV13 vaccine on of 69. R36 was overdue for a					
	registered nurse (R vaccines were offer reviewed during can Minimum Data Set had a master list of the majority of resid						
	stated she was uns	6/30/21, at 3:01 p.m. DON sure of the process, and cy would keep track of this.					
	Records regarding contraindication, an but not provided.	resident education, nd/or refusal were requested					
	indicated prior to or will be assessed for pneumococcal vacc indicated, will be off thirty (30) days of a	ccine policy dated 07/2019, r upon admission, residents r eligibility to receive the cine series, and when fered the vaccine series within idmission to the facility unless licated or the resident has nated.					

Facility ID: 00655

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 16, 2021

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

Re: State Nursing Home Licensing Orders Event ID: 09ET11

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>. 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

Appleton Area Health July 16, 2021 Page 2

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,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health

Appleton Area Health July 16, 2021 Page 3 Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00655	B. WING		06/3	0/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
APPLET	ON AREA HEALTH	30 S BEHI APPLETO	L ST N, MN 5620	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	conducted at your f Minnesota Departm facility was found N State Licensure and orders are issued. I electronic plan of co	rS: , a licensing survey was acility by surveyors from the nent of Health (MDH). Your OT in compliance with the MN d the following correction Please indicate in your prrection you have reviewed				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE 07/23/21

Electronically Signed

STATE FORM

If continuation sheet 1 of 38

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00655	B. WING	B. WING		
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
APPLET	ON AREA HEALTH	30 S BEH APPLET	IL ST ON, MN 56208	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ige 1	2 000			
	these orders and identify the date when they will be completed.					
	the State Licensing federal software. Ta assigned to Minnes Nursing Homes. Th appears in the far le Tag." The state sta listed in the "Summ column and replace the correction order the findings which a statute after the sta as evidence by." Fo are the Suggested Time period for Con You have agreed to receipt of State lice the Minnesota Dep Informational Bullet https://www.health. n/infobulletins/ib14_ orders are delineat	participate in the electronic nsure orders consistent with artment of Health				
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th	Although no plan of correction ate Statutes/Rules, please rected" in the box available for i indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the				
	FOURTH COLUMN "PROVIDER'S PLA	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.				

O9ET11

PPLETOR           (X4) ID           PREFIX           TAG           2 000           1	(EACH DEFICIENCY	30 S BE	B. WING DDRESS, CITY, S' HL ST ON, MN 56208 ID PREFIX		06/	30/2021
PPLETOR           (X4) ID           PREFIX           TAG           2 000           1	N AREA HEALTH SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	30 S BEI APPLET TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	HL ST ON, MN 56208			
(X4) ID REFIX TAG 2 000 (	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L	APPLET TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ON, MN 56208	3		
2 000 (	(EACH DEFICIENCY REGULATORY OR L	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID			
Г	Continued From pa		TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETI DATE
0	THIS WILL APPEA S NO REQUIREM CORRECTION FO	ge 2 R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF R VIOLATIONS OF E STATUTES/RULES.	2 000			
C 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ALZHEIMER'S DIS ALZHEIMER'S DIS DISORDER TRAIN WN St. Statute 144 (a) If a nursing facil Alzheimer's disease or related of segregated or gene care staff and their superviso care. (b) Areas of require (1) an explanation of celated disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shall written or electronic	EASE OR RELATED ING: .6503 ity serves persons with disorders, whether in a eral unit, the facility's direct rs must be trained in dementia ed training include: of Alzheimer's disease and activities of daily living; with challenging behaviors;	2 302			8/4/21
t ( t	opics covered. d) The facility shall his section.	ent is not met as evidenced				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED 06/30/2021	
		00655	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
APPLET	ON AREA HEALTH	30 S BEH APPLETO	IL ST DN, MN 562	)8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 302	Continued From pa	ige 3	2 302			
	facility failed to ens staff and their supe included all require Alzheimer's/demen to affect all 25 resid	and document review, the ure the facility's direct care rvisors received training that d components of tia care. This had the potential dents currently residing in the osis of Alzheimer's or		Corrected.		
	Findings include:					
	social services (SS Hand in Hand - Mo with new employee provided the trainin completed the NetL	on 6/30/21, at 3:40 p.m. )-A stated all staff completed dule 1 dementia care training orientation (NEO) and she g. SS-A further stated staff Learning module Providing are to Older Adults annually ementia".				
	indicated the modu Alzheimer's disease However, the modu with activities of data	Module 1 information provided le included an explanation of e and related disorders. Ile did not cover assistance ily living (ADLs), problem Iging behaviors, and Ils as required.				
	Adults information did not cover assist	Appropriate Care to Older provided indicated the module tance with ADLs, problem iging behaviors, and Is as required.				
	acknowledged Han	on 6/30/21, at 4:47 p.m. SS-A d in Hand training provided to er all required areas.				
		RN)-A hired 5/28/20, education ence the required dementia				

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	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00655	B. WING		06/	30/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
APPLET	ON AREA HEALTH	30 S BEI APPLET	HL ST ON, MN 56208	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 302	Continued From pa	ge 4	2 302			
	care training was re	eceived.				
		7, education record lacked ed dementia care training was				
	Nursing assistant (NA)-E hired 2/26/21, education record lacked evidence the required dementia care training was received.		1			
		, education record lacked ed dementia care training was				
		education record lacked ed dementia care training was	5			
		nurse (LPN)-B hired 2/6/13, cked evidence the required ing was received.				
	9/11/18, education	f nursing (ADON) hired record lacked evidence the care training was received.				
	policy approved 6/2 in-services would in the care of resident and include training	ning Program, Nurse Aide 020, indicated annual iclude "training that addressed is with cognitive impairment; i in dementia management". did not address NEO ing.	ł			
	The administrator of review, and /or revised ensure all direct can receive training on	HODS OF CORRECTION: or designee could develop, se policies and procedures to re staff and their supervisors required areas of tia care. The administrator or				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00655	B. WING		06/30/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
APPLET	ON AREA HEALTH	30 S BEH APPLETC	L ST DN, MN 5620	08		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLET DATE
2 302	Continued From pa	ge 5	2 302			
	ensure ongoing con	elop monitoring systems to npliance and report those / assurance committee.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	) Subp. 1 Adequate and e; General	2 830			8/4/21
	receive nursing care custodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from th	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident bed.				
	by: Based on observati review, the facility fa protective measure residents who were smoke while using p residents (R23) who the facility. The defi Immediate Jeopard at risk for significan	ent is not met as evidenced on, interview, and document ailed to establish adequate s and supervision to ensure dependent on oxygen did not portable oxygen for 1 of 4 o were listed as smokers in ciency was issued at y (IJ) level as R23 remained t injury or death related to en was in use. The facility		Corrected.		

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00655	B. WING		06/	30/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
APPLET	ON AREA HEALTH	30 S BEI APPLET	HL ST ON, MN 56208	ł		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 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. whe was observed smoking a cigarette in the designated smoking area while using a port oxygen concentrator via nasal cannula and oxygen was observed to be turned on. Smo cigarettes in conjunction with using oxygen rapidly accelerate combustion. This could re in significant injury or death to the residents and visitors in the area. The Administrator a Director of Nursing (DON) were notified of t immediate jeopardy at 1:36 p.m. on 6/29/21 immediate jeopardy was removed on 6/30/2 1:38 p.m. but non-compliance remained at a isolated scope and severity which indicated actual harm with potential for more than mir harm (Level D).	king a cigarette in the g area while using a portable or via nasal cannula and the red to be turned on. Smoking action with using oxygen can combustion. This could result or death to the residents, staff area. The Administrator and (DON) were notified of the y at 1:36 p.m. on 6/29/21. The y was removed on 6/30/21, at compliance remained at an severity which indicated no				
	4/28/21, included R Mental Status (BIM indicating R23 was required extensive daily living, locomo dependent on oxyg documentation of R face sheet identified	imum Data Set (MDS) dated 23 had a Brief Interview for S) score of 13 out of 15, cognitively intact. R23 assistance with activities of tion via wheelchair, and was en. The quarterly MDS lacked 23's tobacco status. R23's d diagnoses included heart failure, and chronic ary disease.	I			
	had limited physica and was dependen	vised 2/15/21, reported R23 I mobility, used a wheelchair, t on staff for mobility/wheeling tinations. R23 required use of				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00655	B. WING		06/30/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	1	
		30 S BEI		,		
APPLEI	ON AREA HEALTH	APPLET	ON, MN 56208	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 7	2 830			
	breath with exertion plan indicated R23 known. The smokin indicated R23 smol and was O2 depend listed R23 would sm injury, follow guideli areas. Interventions staff were to assist ensure O2 was turn cannula prior to R22 returning to residen apply nasal cannula on. The care plan id	(O2) and became short of h, even when talking. The care was able to make needs ing focus area of the care plan ked three to four times per day dent. A goal revised 2/12/20, noke without supervision or ines, and smoke in designated s revised 2/11/21, included R23 to smoking location, hed off, and remove the nasal 3 lighting a cigarette. Upon ht, staff were to immediately a and turn the O2 concentrator dentified R23 could light and cigarettes, and keep lighter elf.				
	4/28/21, at 3:20 p.m cognitive loss, visua problems. The asse capable of lighting H assistance getting t and did not need th and cigarettes. A no "IDT [interdisciplina A/O [alert and orien light cigarette on ov cigarette. Understa allowed. Needs ass designated smoking be off when smoking the assessment rea Staff will escort the Turn off oxygen. W to alert staff when v turn O2 back on. St	tety Screen assessment dated n. indicated R23 had no al deficits, or dexterity essment indicated R23 was her own cigarette, required to and from the smoking area, he facility to store her lighter ote on the assessment read, iry team] feel the resident is nted], cognitively intact. Able to wn. Can control ashes from nds location where smoking is sistance to get to/from g area. Understands O2 must ng." Conditions also included ir ad, "Will request to smoke. resident to the smoking area. ill use Walkie Talkie or phone would like to come in. Staff will taff escort back into building. ble to apply per self, aware of	1			

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00655	B. WING		06/	30/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
APPLET	ON AREA HEALTH	30 S BEI APPLET	HL ST ON, MN 56208	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 8	2 830			
	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%. 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.					
	nursing assistant (I smoked was asses safe. She stated R2 designated smokin independently. NA- was powered on ur area. Once there, s removed the nasal on the back of the n stated residents we for staff assistance smoking area.	n 6/29/21, at 9:44 a.m. certified NA)-F stated anyone who seed to make sure they were 23 needed help to get to the g area but could smoke F stated the O2 concentrator ntil R23 arrived at the smoking staff turned off the O2, cannula, and hung the tubing resident's wheel chair. She ere given a 'walkie' and called when they wanted to leave the				
	was smoking in the a nasal cannula in	6/29/21, at 10:28 a.m. R23 e designated smoking area with her nose. R23's oxygen off and placed on a chair to the	ו			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00655	B. WING		06/30/2021		
AME OF F	ROVIDER OR SUPPLIER		ET ADDRESS, CITY, STATE, ZIP CODE				
	ON AREA HEALTH	30 S BEI					
FFLEI		APPLET	ON, MN 56208	3			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	ge 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.						
	10:49 a.m. director registered nurse (R smoking area. R23 hand. Her oxygen of indicated by the dig oxygen tubing was cannula was in R23 approximately 5 fee The two residents w confirmed the conc immediately turned immediately turned immediately turned immediate educatio when wearing O2 w requested R23 rem however R23 refuse smoking materials R23 stated she was her nasal cannula w placed her cigarette DON's offer to trans called for alternate the building. R23 re and RN-B until 10:5	nt observation on 6/29/21, at of nursing (DON) and N)-B were brought to the had a lit cigarette in her right concentrator was turned on as ital display on the unit. The connected to the unit and the B's nose. Another resident sat et from R23 with a lit cigarette. vere facing each other. DON entrator was turned on and it off. DON provided on to R23 regarding smoking vas a safety hazard. DON ove the nasal cannula, ed. DON requested all from R23 but R23 refused. s not previously told to remove when smoking. R23 then e in the receptacle, refused sport her into the facility, and assistance to go back into to emained supervised by DON 53 a.m. when NA-G arrived. 6 to her room at 10:57 a.m.					
	stated wearing O2	on 6/29/21, at 10:53 a.m. DON while smoking was expectation was residents					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED		
		00655	B. WING		06/30/2021			
IAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE				
APPLETON AREA HEALTH 30 S BEHL ST APPLETON, MN 56208								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE		
2 830	removed the nasal stated her preference brought to the smok confirmed R23 was regarding the dange agreed to remove the to smoke, but still re- concentrator remain smoke. DON stated reassessed with ne- safety. R23's progress note identified, "Reporter outside in the desig with surveyor and s oxygen on. Resider she was tearful stat cigarette and turner outside visiting. She was on and lit a cig she had taken two p policy with resident Explained to reside and she would have and that smoking sin nurse's desk. Oxyg- would not be taken Resident became u stating, What kind com explosion, and poss it has been done in telling staff that they did calm down with and four cigarettes. anymore in her roor smoking plan, reside	cannula prior to smoking. She ce was oxygen was not king area at all. DON re-educated immediately ers of smoking with O2. R23 ne O2 cannula when going out equested the oxygen n with her when she went to						

STATEMEN	<u>ota Department of He</u> NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/30/2021	
		00655	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
APPLET	ON AREA HEALTH	30 S BEI APPLET	HL ST ON, MN 56208	ł		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 11	2 830			
	expiration of 7/19 o patients, tenants, v policy identified the visitors and long ten were in the LTC cen side near the kitche end of the west par dumpster, and on the under the shade tree for safe smoking as any requirement to smoking. No addition related to smoking smoking were prov		5			
	11:47 a.m. identifie smoke with supervi	ty Screen dated 6/29/21, at d R23 was reassessed safe to ision and one-to-one sility would store R23's lighter				
	12:52 p.m. R23 put entered R23's room cannula and conce then pushed R23 to checked R23's oxy a bag containing R2 the medication room transported R23 to where R23 smoked NA-K.	observation on 6/30/21, at con her call light. NA-K n, removed R23's nasal ntrator from her wheelchair o the nursing station. NA-K gen saturation level, retrieved 23's smoking supplies from m, and gave it to R23. NA-K the designated smoking area d a cigarette accompanied by				
	-At 1:03 p.m. NA-K -At 1:12 p.m. R23 p receptacle and requination NA-F transported F checked R23's O2	was replaced by NA-F. placed her cigarette in the uested to return to her room. R23 to the nursing station, saturation level, placed the ter and cigarettes in the				

					E SURVEY PLETED		
00655		B. WING		06/30/2021			
SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE				
EALTH							
4) ID SUMMARY STATEMENT OF DEFICIENCIES IEFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL AG REGULATORY OR LSC IDENTIFYING INFORMATION)		SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECT(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOUREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPRO				TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
n room, and ret F placed the na f on the oxygen aff supervision. diate jeopardy f ved on 6/30/21, ed, based on ob cility successfu an which includ educated rega ge in R23's sm nt of R23's nasal tor prior to trans d smoking area orage of R23's g R23's O2 satu after smoking after smoking ttes and lighters session. R23 w the risk of smo was updated to nula will remain nts who smoke ed for safe smo y smoking after nanges of cond ty. Education o	asal cannula on R23 A R23 was never left that began on 6/29/21, at 1:38 p.m. when it oservation and interview ly implemented a ded the following: rding: oking supervision cannula and oxygen sportation to the cigarettes and lighter uration levels both s were removed from as re-educated king with oxygen, and reflect oxygen and in R23's room while d, including R23, were king. y was reviewed for include LTC residents ssment on admission, admission, quarterly, ition which include n smoking cessation	2 830	DEFICIENC	<u>CY)</u>			
	SUPPLIER SUPPLIER EALTH MARY STATEMENT DEFICIENCY MUST TORY OR LSC IDEN I From page 12 In room, and retu- F placed the na d on the oxygen aff supervision. I figure geopardy for ved on 6/30/21, ed, based on ob cility successful lan which include e educated rega ge in R23's nasal tor prior to trans d smoking area orage of R23's sm int of R23's nasal tor prior to trans d smoking area orage of R23's g R23's O2 satu d after smoking ttes and lighters session. R23 w the risk of smol was updated to nula will remain nts who smoke ed for safe smoc y smoking after hanges of cond ty. Education of addressed with	ION         IDENTIFICATION NUMBER:           00655         00655           SUPPLIER         STREET A           EALTH         30 S BE           MMARY STATEMENT OF DEFICIENCIES         DEFICIENCY MUST BE PRECEDED BY FULL           MARY OR LSC IDENTIFYING INFORMATION)         IFrom page 12           In room, and returned R23 to her room         F placed the nasal cannula on R23 do n the oxygen. R23 was never left aff supervision.           Idiate jeopardy that began on 6/29/21, ved on 6/30/21, at 1:38 p.m. when it ed, based on observation and interview cility successfully implemented a lan which included the following:           educated regarding:           ge in R23's smoking supervision int           of R23's nasal cannula and oxygen tor prior to transportation to the d smoking area           orage of R23's cigarettes and lighter g R23's O2 saturation levels both d after smoking           dafter smoking           ttes and lighters were removed from session. R23 was re-educated the risk of smoking with oxygen, and was updated to reflect oxygen and nula will remain in R23's room while           nts who smoked, including R23, were ed for safe smoking.           y smoking policy was reviewed for and updated to include LTC residents a smoking assessment on admission, f smoking after admission, quarterly, hanges of condition which include ty. Education on smoking cessation addressed with each assessment and	IDENTIFICATION NUMBER:       A. BUILDING:	ION       DENTIFICATION NUMBER:       A. BUILDING:         00655       B. WING         SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         BALTH       30 S BEHL ST APPLETON, MN 56208         MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL TORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCY TAG         IF rom page 12       2 830         In room, and returned R23 to her room -F placed the nasal cannula on R23 d on the oxygen. R23 was never left aff supervision.       2 830         diate jeopardy that began on 6/29/21, ved on 6/30/21, at 1:38 p.m. when it ad, based on observation and interview cility successfully implemented a lan which included the following: -educated regarding: ge in R23's masal cannula and oxygen tor prior to transportation to the d smoking area orage of R23's O2 saturation levels both d after smoking the rank of smoking with oxygen, and was updated to reflect oxygen and nula will remain in R23's room while nts who smoked, including R23, were ed for safe smoking.         y smoking policy was reviewed for and updated to include LTC residents is emoking after admission, f smoking after admission, f smoking after admission, quarterly, hanges of condition which include ty. Education on smoking cessation addressed with each assessment and	ION     IDENTIFICATION NUMBER:     A. BUILDING:     COM       00655     B. WING     06/       SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       EALTH     30 S BEHL ST APPLETON, MN 55208       INMAY STATEMENT OF DEFICIES DEFICIENCY MUST BE PRECEDED BY FULL TAG     Image: Construction of Consection (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       IF or page 12     2 830       r forwn, and returned R23 to her room -F placed the nasal cannula on R23 d on the oxygen. R23 was never left aff supervision.     2 830       diate jeopardy that began on 6/29/21, ved on 6/30/21, at 1:38 p.m. when it ad, based on observation and interview cility successfully implemented a lan which included the following: -educated regarding: ge in R23's smoking supervision nt or roage of R23's cigarettes and lighter g R23's Q2 saturation levels both 1 after smoking the sand lighters were removed from session. R23 was re-educated the risk of smoking area orage of R23's cogarettes and lighter g R23's Q2 saturation levels both 1 after smoking.       rts who smoked, including R23, were ed for safe smoking. y smoking policy was reviewed for and updated to include LTC residents is smoking assessment on admission, to smoking assessment on admission, y smoking assessment on admission, to didressed with each assessment and		

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00655	B. WING		06/	30/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
APPLET	ON AREA HEALTH	30 S BEH APPLET	IL ST ON, MN 56208	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	age 13	2 830			
	device. All smoking medication room for oxygen. Oxygen, na remain in the reside the designated smo require supervision to the smoking area for the duration of t without the dexterit prohibited from smo supervision or inde smoking assessme and updated when	oxygen mask or other delivery g materials will be stored in the or residents who require asal cannula and mask will ent's room while smoking in oking area. Residents who will be accompanied by staff a and remain with the resident he smoke break. Residents y to hold a cigarette will be oking. The need for pendent will be reflected in the ent, addressed in the care plan indicated. The care center o prohibit smoking when there to patient safety.				
	included acute on o heart failure, adjust mood, major depre	ndated, indicated diagnosis chronic diastolic (congestive) tment disorder with depressed ssive disorder, chronic ary disease, and anxiety				
	5/4/21, indicated m R25's MDS further	imum data set (MDS) dated oderate cognitive impairment. indicated need for assistance essing and personal hygiene.				
	resident has an act self-care performar CHF, hx of bilateral moderate cognitive indicated the reside	vised on 6/15/21, indicated the ivity of daily living (ADL) nce deficit r/t chronic diastolic I pleural effusion, and deficit. R25's care plan furthe ent has congestive heart failure uld be monitored weekly.				
		lations percentage loss on sident weighed 204.6 lbs. On				

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NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
APPLET	ON AREA HEALTH	30 S BEI APPLET	HL ST ON, MN 56208	ł		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
2 830	-	0	2 830			
		06/16/2021, the resident weighed 193.3 pounds which is a -5.52 % Loss.				
	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		a			
	failure. Recommen amlodipine to 10 m make his periphera zaroxolyn 2.5 mg b morning with his La	dation included changing g as amlodipine is likely to Il edema worse. Start y mouth every other day in the asix to see if we can reduce his ion and peripheral edema.				
	(diuretic) 80 mg by	ers dated 6/19/21 Lasix mouth every morning for CHF th every evening for CHF.				
	indicated new orde per week, one time Wednesday, and F	d 6/23/21, at 11:20 am r to obtain weights three times a day every Monday, riday for weight loss and tion precautions for C-diff.				
	Staff care guide shu indicated R25 shou Wednesdays.	eets updated 6/29/21, Ild be weighed on				
	weight done on 6/1 other documentation	ited 7/1/21, indicated last 6/21 was 193.2. The only on of weight was 5/19/21 which a wheelchair), and 5/17/21				
	medication aide (TI be monitored for we his current infection	6/29/21, at 12:59 p.m. trained MA)-A indicated resident is to eights due to weight loss and n of c-diff. TMA stated the (NA) weigh the residents and	I			

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		00655		B. WING		06/30/2021		
NAME OF I	PROVIDER OR SUPPLIER		B. WING         06/30/2021           ADDRESS, CITY, STATE, ZIP CODE         06/30/2021					
APPLETON AREA HEALTH 30 S BEHL ST APPLETON, MN 56208								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
2 830	Continued From pa	ige 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.							
	practical nurse (LPI diagnosis of c-diff a weights due to weig now they have no w his room due to bei he thinks they could clean the machine, attention of the regi confirmed R25 sho times a week Mono and stated "It was a order". LPN-A state weight loss with R2 computer while talk classify his weight I LPN-A further state should be notified a	6/29/21, at 1:15 p.m. licensed N)-A stated R25 has a and staff are monitoring his ght loss. LPN-A stated right vay of weighing him outside of ing on precautions, however d use the hoyer lift and just but has not brought this to the istered nurses. LPN-A uld be being weighed three day, Wednesday and Friday, a nursing order not a provider ed he was not aware of any 55 until he looked into the sting and stated he would oss as a significant loss. a the provider and dietician as well to further monitor.						
	stated R25 should l which was Wednes nurse if he refused.	be weighed on his bath days day and then reported to the NA-B stated it was important to make sure their weights are						
	stated R25 was put has c-diff and it was weights to make su weight. The dieticia was up to 204, but 193 and stated the	6/29/21, at 4:14 p.m. Dietician t on strong diuretics and now s important to monitor his irre he has not lost any more in stated she sees his weight he is now back to baseline at y should be monitoring his e he is not losing anymore						

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00655	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
APPLET	ON AREA HEALTH	30 S BEH APPLET	HL ST ON, MN 56208	8		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CO       (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE ACTION			
2 830	that was put in by n times a week weigh be weighting him. During interview on registered nurse (R residents should be however with R25 t just put in for three stated she would be residents and if the that it should be rep stated it was import he was on diuretics status and c-diff.	an stated she sees an order ursing on 6/18/21 for three hts and would expect staff to 6/29/21, at 4:51 p.m. N)-A stated in general all weighed at least weekly, here was an order that was times a week weights. RN-A e expecting staff to weigh y were unable to weigh him ported to the RN's. RN-A cant to monitor R25's weight as and due to his nutritional	2 830			
	stated R25 should t times a week and if should be done ond it is not ok to go a n and it is important to being on diuretics a for a decline in state					
	director of nursing ( a weight that states she would expect th three times a week aware that he was n way of weighing R2 stated there are wa precautions if that n scale or bringing re residents were in th precautions. DON s	6/30/21, at 10:35 a.m. the DON) stated if a resident has three times a week weights, his resident to be weighed . DON stated she was not hot being weighed or had no 5 due to precautions. DON ys to weigh someone on neant getting a new mobile sident out when no other he hallway to keep isolation stated it was important to or his status and make sure				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00655	B. WING		06/	30/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE	·	
APPLET	ON AREA HEALTH	30 S BEH APPLET	IL ST DN, MN 56208			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa weight with the diur	-	2 830			
	expires 6/21, "The strive to prevent, m undesirable weight Weights will be rec record chart or note medical record. An more since the last retaken the next da weight is verified nu	at and intervention policy multidisciplinary team will ionitor, and intervene for loss for our residents. orded in each unit's weight ebook and in the individual's y weight change of 5% or weight assessment will be ay for confirmation. If the ursing will immediately notify ng. Verbal notification be g".				
	diabetes type 2 with diabetes mellitus w disease, and esser	undated, indicated diagnosis: h diabetic polyneuropathy, ith diabetic chronic kidney ntial hypertension. PS dated 6/3/21, identified no				
	cognitive impairme R41's provider orde Novolog FlexPen S UNIT/ML (Insulin A down blood sugar) - 149 = 0; 150 - 200 = 6; 301 - 350 = 8; subcutaneously be related to TYPE 2 I					
	indicated blood sug	vital summary dated 6/29/21, gar on 6/28/21 at 12:01 was 15/21 at 10:51 pm blood sugar				
	During interview on	n 6/29/21, at 1:05 p.m. LPN-A				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
APPLET	ON AREA HEALTH	30 S BEH APPLETO	L ST DN, MN 56208	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
2 830	Continued From parts stated he was awar 442 on 6/28/21, but R41 eating ice creat use your common as provider ". LPN-A staprovider orders have according and assessed R41 symptoms so he gat follow the order and stated he could not 6/28/21 nor 6/15/21 elevated. During interview on Dietician reviewed I residents blood sug providers orders the notified and is unact the provider. The dimportant to notify pas it could mean the adjusted or there is the resident. During interview on nurse (RN)-B stated would provider and it was not to notify the pro ice cream. RN-B state providers orders. During interview on nurse (RN)-B stated would provider and it was not to notify the pro ice cream. RN-B state providers orders.		2 830			
	R41's Novolog orde the nurse should be	ers any blood sugar over 351 e giving him 10 units of insulin rider. DON stated it is nursing				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:	······		
		00655	B. WING		06/	30/2021
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PPLET	ON AREA HEALTH	30 S BEI				
		APPLET	ON, MN 56208	}		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC <sup>-</sup> CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 19	2 830			
	standards to follow provider if the orde out of the normal d DON further stated provider in case the medication. DON fit changing the settin point click care as is sure an outcome w Diabetes-Clinical p " The physician will episodes associate change in blood su of previous glucose resident status at s situation is resolved desired parameters information related The staff will incorp the medication adm plan. The staff will may affect, or be a and diabetes mana skin ulceration, inco "	provider orders and notify the r states to or the blood sugar is espite R41 having ice cream. I it was important to notify the e provider needed to adjust his urther stated she will be gs for his orders/parameter in it has the capability to make				
	was severely cogni sometimes able to sometimes able to diagnoses included	OS dated 4/6/21, indicated R13 itively impaired, she was make herself understood and understand others. R13's d dementia, diabetes, anxiety, neart failure. R13 was able to				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00655	B. WING		06/	30/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
APPLET	ON AREA HEALTH	30 S BEH APPLET	IL ST ON, MN 56208	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 20	2 830			
	move her upper ext	tremities without limitations.				
	was noted to have a that started at her w approximately halfw elbow. The bruise a The bruise was at w noted was a large, the base of her left back of her hand. F scattered, deep pur	on 6/28/21, at 12:05 p.m. R13 a large bruise on her left arm wrist and extended to vay between her wrist and her also wrapped around her arm. various stages of healing. Also deep purple bruise starting at thumb and extended to the R13 had several smaller, rple bruises on her right arm. o explain how she got the				
		ed to identify the bruising. assessments completed				
	(NA)-A confirmed th arms and stated sh bruising but was no there. NA-A explain nurse, when doing of what it is. If it is son that resident, such would first talk with nursing assistant, to reported. NA-A did R13's arms. NA-A w reported this, indica another nursing assistant assist does not become p resistive with cares	8 p.m. nursing assistant ne bruising on both R13's e had previously noted the it sure how long they had been ed what she reports to the daily skin checks, depends on nething that is common for as the bruising is for R13, she her co-worker, another o decide if it needs to be not recognize the bruising on was not sure if she would have ating she would talk with sistant first. NA-A stated R13 hysically aggressive or but does swing her arms ets excited and is happy.				
		p.m. licensed practical nurse he was aware of the bruising				

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		00655	B. WING		06/	30/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
APPLET	ON AREA HEALTH	30 S BEI APPLET	HL ST ON, MN 56208	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 21	2 830			
	happened. LPN-A o	vas not aware of how they confirmed they were not sing or documenting in the				
	bruises located on is given her call ligh use it. She would o staff attention. LPN previously made no and discussions with	p.m. LPN-B confirmed the R13's arms. She stated, R13 ht, but does not consistently ften slap her arms to get the I-B indicated she had made otes regarding R13's bruising th R13's daughter about the notes were requested but were				
	stated she expecte changes, including nurse and document reported skin conce be documented in t and appearance. B monitored either da the severity of it. Br decide the cause a RN-B indicated she	' p.m. registered nurse (RN)-B d all skin concerns or bruising, were reported to the nted. This included previously erns. Reported bruises should the progress notes with size ruising should then be aily or weekly, depending on ruises are investigated to nd how to avoid recurrence. was not aware of R13's s, but confirmed size, location of healing.				
	(DON) stated anyth existing, needed to bruise that is fading a known cause is s documented. If a re	p.m. director of nursing ning that was seen, new or be documented, even if it is a g. DON expected bruising with till investigated and esident bruises easily, then the cause so changes can be uising.				
	A facility policy rega requested but was epartment of Health	arding skin checks was not received.				

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STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00655	B. WING		06/	30/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
APPLET	ON AREA HEALTH	30 S BEI APPLET	HL ST ON, MN 56208	6		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ige 22	2 830			
	included morbid ob hypoventilation (slo edema, unspecified failure, pulmonary f mellitus with diabet borderline personal disorder. R3's quarterly minin 3/11/21, indicated of further indicated ne for bed mobility, tra toilet use, and pers R3's care plan revis resident on diuretic (HTN) medications kidney disease (CK care plan further im- side effects and eff vital signs (VS) at le prn (as needed), ar wt. gain or abnorma R3's signed provide 5/13/21, indicated of	w/shallow breathing), localized diastolic (congestive) heart hypertension, type 2 diabetes ic neuropathy, schizophrenia, lity disorder, and anxiety mum data set (MDS) dated cognition intact. R3's MDS sed for extensive assist of one nsfers, ambulation, dressing,				
	5/13/21, indicated r by mouth one time related to localized Additionally, provide bumetanide (diuret	er order summary dated netolazone (diuretic) 2.5 mg a day every Mon, Wed, Fri edema was initiated 11/13/17. er order dated 1/24/20, ic) 1 mg by mouth two times a ecified diastolic (congestive)				

STATEMEI	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
APPLET	ON AREA HEALTH	30 S BEI APPLET	HL ST ON, MN 56208	5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETI DATE	
2 830	R3's weight summa documented weight were obtained 1/8/2 2/2/21, 2/5/21, 2/9/2 3/5/21, 3/9/21, 3/12 3/31/21, 4/8/21, 4/9 5/4/21, 5/5/21, 5/7/2 6/1/21, 6/8/21, 6/15 During interview on practical nurse (LPN weight taken on Tue R3's electronic heal stated "I see the ord Wednesday, Friday LPN-B further state only one time a wee weights was "overa During interview on registered nurse ca charge nurse monit stated the charge n prior to provider visi were requested, an standup meetings. I orders were not follo During interview on director of nursing ( expected to follow p nurses were expect DON further stated weighed, she would completed an asses provider after the res	<ul> <li>ary dated 7/1/21, indicated</li> <li>ary dated 7/1/21, indicated</li> <li>as from the last six months</li> <li>ary 1/19/21, 1/22/21, 1/29/21,</li> <li>ary 1/19/21, 2/23/21, 3/2/21,</li> <li>ary 1/1/21, 2/23/21, 3/26/21,</li> <li>ary 1/21, 3/16/21, 3/23/21, 3/26/21,</li> <li>ary 1/21, 5/18/21, 3/26/21,</li> <li>ary 1/21, 5/18/21, 3/26/21,</li> <li>ary 1/21, 3/26/21, at 9/29/21,</li> <li>ary 1/21, and 6/29/21.</li> <li>ary 1/21, at 9/29 a.m. licensed</li> <li>brow for Monday,</li> <li>ary 1/21, at 9/29 a.m. licensed</li> <li>brow for Monday,</li> <li>brow for Monday,</li> <li>brow for Monday,</li> <li>cond (EHR), LPN-B</li> <li>der now for Monday,</li> <li>brow for Monday,</li> <li>cond (EHR), LPN-B</li> <li>der now for Monday,</li> <li>brow for Monday,</li> <li>cond (EHR), LPN-B</li> <li>der now for Monday,</li> <li>are and effort".</li> </ul> 6/30/21, at 11:13 a.m. remanager (RN)-A stated the ored weights were reviewed at RN-A further stated if provider orders for weights and the management of a resident refused to be an expect the nurse to assess for weights. The if a resident refused to be assess the and notified the exident's third refusal. N stated she expected orders for the fuse and the exident's third refusal. N stated she expected orde	4				

STATEMEN	D <u>ta Department of He</u> NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED		
		00655	B. WING		06/	30/2021		
NAME OF I	PROVIDER OR SUPPLIER			TATE, ZIP CODE				
APPLETON AREA HEALTH 30 S BEHL ST APPLETON, MN 56208								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE		
2 830	Continued From pa	ige 24	2 830		·			
	R24 was cognitively wheelchair for locor assistance/supervis The MDS identified congestive heart fa kidney failure, and R24's care plan dat intervention to weig which was to be co under the same con clothing.	S dated 4/29/21, indicated y intact, used a walker or motion, and required limited sion with walking and toileting. diagnoses which included ilure, high blood pressure, dementia. ted 2/14/21, included an yh R24 as ordered by provider mpleted at the same time nditions with same amount of						
	order for daily weig	hts relating to diagnosis of ilure with a start date of						
	lacked documentat 104 days between 2	ministration record (TAR) ion of daily weights on 30 of 2/15/21, and 6/28/21. No sing values were recorded on es.						
	stated she expected followed. She state complete she expe	6/30/21, at 2:51 p.m. DON d provider orders to have beer d if the TAR noted a task was cted it to have been completed be considered falsification.						
	and stated she obs TAR and acknowled documented as hav were recorded in R She stated they [sta was not completed]	I's daily weight documentation erved gaps. She reviewed the dged there were more weights ving been completed than 24's vital sign documentation. aff] signed off something that , and her expectation was ecorded and signed off only						

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00655	B. WING		06/	30/2021
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
PPLET	ON AREA HEALTH	30 S BEI APPLET	HL ST ON, MN 56208	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	ge 25	2 830			
	The director of nurse develop policy and regarding the follow keep resident who conducting weights orders, monitoring of blood glucose per p designee could con staff to ensure daily according to physic physician is notified there is documenta monitored and ensu- including appropriation	HOD OF CORRECTION: sing and/or designee could educate responsible staff ving: policy and procedure to smoke and use oxygen safe, according to physician's of bruising, and reporting of ohysician orders. The DON or iduct audits of responsible vweights are completed ian orders, to ensure I as orders dictate, to ensure tion that bruises are being ure procedures are followed te supervision of residents formation could be brought to review.				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one				
2 920	MN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	2 920			8/4/21
	comprehensive res home must ensure B. a resident who activities of daily liv	is unable to carry out ing receives the necessary n good nutrition, grooming,				
	by:	ent is not met as evidenced				
	Based on observati	on, interview and document		Corrected.		

STATE FORM

O9ET11

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00655	B. WING		06/	30/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
APPLET	ON AREA HEALTH	30 S BEH APPLET	IL ST ON, MN 56208	ł		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	offered or provided R27) in the sample staff for assistance (ADLs). Findings include: R25's face sheet un included acute on c heart failure, adjust mood, major depres obstructive pulmona disorder. R25's quarterly min 5/4/21, indicated mo R25's MDS further i of one assist for dre R25's care plan rev resident has an ADI r/t chronic diastolic effusion, moderate atrial fibrillation hyp with pacemaker, hy history of depressio the resident prefers sha shave on own after Clean shaver for the During observation 12:42 p.m. R25 was approximately 1/4 ir cheeks, chin, neck,	ailed to ensure shaving was for 2 of 3 residents (R25 and who were dependent upon with activities of daily living addated, indicated diagnosis hronic diastolic (congestive) ment disorder with depressed asive disorder, chronic ary disease, and anxiety imum data set (MDS) dated oderate cognitive impairment. ndicated need for assistance assing and personal hygiene. ised on 6/15/21, indicated the self-care performance deficit CHF, hx of bilateral pleural cognitive deficit. Paroxysmal ertension, 3rd degree av block pothyroidism, anxiety and n with interventions listed as ed dressing/grooming routine kfast. Personal hygiene: the ave every morning. Able to set up. Touch up as needed.		DEFICIENC		

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00655	B. WING		06/	30/2021
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
ON AREA HEALTH			1		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
During observation sitting in his recliner unshaven, hair rem on face and chin wh hair. During observation 10:02 a.m. R25 was unshaven with appr and white hair on fa stated "I would like today". During interview on medication aide (TM assistance of one fo dressing, and shavi During interview on practical nurse (LPM assistance with care R25 can shave him do so. LPN-A stated shaved if that is the self esteem and eve best. During interview on	on 06/28/21, 7:28 p.m. R25 r and continued to be ain approximately 1/4 in. long hich was, coarse gray/white and interview on 06/29/21, at s sitting in recliner, remained oximately 1/4 in coarse gray ice, chin and neck. R25 to be shaved some time 6/29/21, at 12:59 p.m. trained MA)-A stated that R25 is or all cares including bathing, ng. 6/29/21, at 1:15 p.m. licensed N)-A stated R25 does require es. LPN-A further stated that self if someone sets him up to d it is important for men to be ir preference as it helps with eryone wants to look their 6/29/21, at 2:15 p.m. nursing	1	DEFICIENC	57)	
getting R25 cloths of process of cleaning that it was importan wanted to be shave on the residents can she had not shaved help with residents NA-B further stated	changed and was in the up the room. NA-B stated t to shave all men who d and this would be indicated re plan. NA-B further stated I R25 as she usually does not getting up in the morning. she wasn't sure if he was or				
	OF CORRECTION PROVIDER OR SUPPLIER ON AREA HEALTH SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa During observation sitting in his recliner unshaven, hair rem on face and chin wh hair. During observation 10:02 a.m. R25 was unshaven with appr and white hair on fa stated "I would like today". During interview on medication aide (TM assistance of one fo dressing, and shavi During interview on practical nurse (LPI assistance with care R25 can shave him do so. LPN-A stated shaved if that is the self esteem and even best. During interview on assistant (NA)-B sta getting R25 cloths of process of cleaning that it was important wanted to be shaved on the residents care she had not shaved help with residents NA-B further stated wasn't shaved yet to	OF CORRECTION       IDENTIFICATION NUMBER:         00655         PROVIDER OR SUPPLIER       STREET A         ON AREA HEALTH       30 S BEI         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       Continued From page 27         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	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         00655       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, ST         ON AREA HEALTH       30 S BEHL ST         APPLETON, MN 56208         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         Continued From page 27       2 920         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.       2 920         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 R25 as she usually does not help with residents ge	OF CORRECTION     IDENTIFICATION NUMBER:     A. BUILDING:       00655     B. WING       PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       ON AREA HEALTH     30 S BEHL ST APPLETON, MN 56208       SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LGC IDENTIFYING INFORMATION)     D PROVIDER'S PLAN OF (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LGC IDENTIFYING INFORMATION)     D PREFIX TAG     D PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCY TAG       Continued From page 27     2 920       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.     2 920       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 '1 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 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 heir 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 R25 as she usually does not help with residents getting up in the morning. NA-B further stated she wasn't swas of wasn't shaved yet today	OF CORRECTION       IDENTIFICATION NUMBER:       A BUILDING:

If continuation sheet 28 of 38

(EACH DEFICIENCY REGULATORY OR LS tinued From pa shaving. NA-B r he will usually sed the nurse s locumented. NA n. ng interview on	30 S BEHI APPLETO TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	B. WING DRESS, CITY, ST L ST N, MN 56208 ID PREFIX TAG 2 920		ECTION HOULD BE	30/2021 (X5) COMPLETE DATE
REA HEALTH SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS tinued From pa shaving. NA-B r he will usually sed the nurse s locumented. NA n. ng interview on	STREET ADI 30 S BEHI APPLETO TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 28 stated if you give him the shave himself and if he hould be notified and it should	L ST N, MN 56208 ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP	ECTION HOULD BE	(X5) COMPLETI
SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS tinued From pa shaving. NA-B r he will usually sed the nurse s locumented. NA n. ng interview on	APPLETO	N, MN 56208 ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP	HOULD BE	COMPLETE
(EACH DEFICIENCY REGULATORY OR LS tinued From pa shaving. NA-B r he will usually sed the nurse s locumented. NA n. ng interview on	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 28 stated if you give him the shave himself and if he hould be notified and it should	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP	HOULD BE	COMPLETE
shaving. NA-B r he will usually sed the nurse s ocumented. NA n. ng interview on	stated if you give him the shave himself and if he hould be notified and it should	2 920			
r he will usually sed the nurse s locumented. NA n. ng interview on	shave himself and if he hould be notified and it should				
ed that all men s earance, if they	6/30/21, at 9:37 a.m. NA-C should be shaved daily for choose.				
pecified dement urbance, deliriur	ia with behavioral n due to known physiological				
lerate cognitive cated R27 requi	impairment. MDS further res assistance of one for nal hygiene which included				
resident has an cit with intervent	ADL self-care performance tions: the resident prefers				
6 p.m. R27 hac se gray/white h w nose. R27 st kes to have his	l approximately 1/4 inch air on cheeks, chin, neck, and ated he wants to be shaved as hair short. R27 was not sure				
ing in the hallw	ay with front wheeled walker.				
ing down hallw					
out 'e set 'e ceut reeve a rei rei	ecified dement rbance, deliriur ition, and anxie s quarterly MD erate cognitive ated R27 requi sing and person bing hair, brush s care plan rev esident has an it with intervent sing/grooming is kfast. ag observation 6 p.m. R27 hac se gray/white h v nose. R27 states to have his ast time he was ast time he was ast time he allw facial hair note	ng observation and interview on 6/29/21, at 6 p.m. R27 had approximately 1/4 inch se gray/white hair on cheeks, chin, neck, and w nose. R27 stated he wants to be shaved as tes to have his hair short. R27 was not sure ast time he was shaved. Ing observation on 6/29/21, at 9:28 a.m. R27 ng in the hallway with front wheeled walker. facial hair noted. Ing observation on 6/29/21, at 12:16 p.m. R27 ng down hallway continue to have	ecified dementia with behavioral rbance, delirium due to known physiological ition, and anxiety. s quarterly MDS dated 5/5/21, indicated erate cognitive impairment. MDS further ated R27 requires assistance of one for sing and personal hygiene which included bing hair, brushing teeth, and shaving. s care plan revised on 11/17/20, indicated esident has an ADL self-care performance it with interventions: the resident prefers sing/grooming routine is done prior to kfast. ng observation and interview on 6/29/21, at 5 p.m. R27 had approximately 1/4 inch se gray/white hair on cheeks, chin, neck, and w nose. R27 stated he wants to be shaved as tes to have his hair short. R27 was not sure ast time he was shaved. ng observation on 6/29/21, at 9:28 a.m. R27 ng in the hallway with front wheeled walker. facial hair noted. ng observation on 6/29/21, at 12:16 p.m. R27 ng down hallway continue to have	ecified dementia with behavioral rbance, delirium due to known physiological ition, and anxiety. s quarterly MDS dated 5/5/21, indicated erate cognitive impairment. MDS further ated R27 requires assistance of one for sing and personal hygiene which included bing hair, brushing teeth, and shaving. s care plan revised on 11/17/20, indicated esident has an ADL self-care performance it with interventions: the resident prefers sing/grooming routine is done prior to cfast. ng observation and interview on 6/29/21, at 5 p.m. R27 had approximately 1/4 inch se gray/white hair on cheeks, chin, neck, and v nose. R27 stated he wants to be shaved as tess to have his hair short. R27 was not sure ast time he was shaved. ng observation on 6/29/21, at 9:28 a.m. R27 ng in the hallway with front wheeled walker. facial hair noted. ng observation on 6/29/21, at 12:16 p.m. R27 ng down hallway continue to have	ecified dementia with behavioral rbance, delirium due to known physiological ition, and anxiety. s quarterly MDS dated 5/5/21, indicated erate cognitive impairment. MDS further ated R27 requires assistance of one for sing and personal hygiene which included oing hair, brushing teeth, and shaving. s care plan revised on 11/17/20, indicated esident has an ADL self-care performance it with interventions: the resident prefers sing/grooming routine is done prior to cfast. ng observation and interview on 6/29/21, at 5 p.m. R27 had approximately 1/4 inch se gray/white hair on cheeks, chin, neck, and v nose. R27 stated he wants to be shaved as tes to have his hair short. R27 was not sure ast time he was shaved. ng observation on 6/29/21, at 9:28 a.m. R27 ng in the hallway with front wheeled walker. facial hair noted. ng observation on 6/29/21, at 12:16 p.m. R27 ng down hallway continue to have

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00055	B. WING			
		00655			06/	30/2021
IAME OF F	PROVIDER OR SUPPLIER	30 S BEI	DDRESS, CITY, S <sup>-</sup> <b>-II ST</b>	IATE, ZIP CODE		
PPLET	ON AREA HEALTH		ON, MN 56208	}		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	nge 29	2 920			
	approximately 1/4 i face and neck.	n. coarse gray/white hair on				
	practical nurse (LP assistance of 1 with	6/29/21, at 1:28 p.m. license N)-A stated R27 requires n all morning and afternoon wing and oral cares, which viding to him.				
	assistant (NA)-B sta	6/29/21, at 2:15 p.m. nursing ated all men should be shaved rence and should be offered	I			
	registered nurse (R himself if you cue h important to assist identify the problem	6/29/21, at 5:16 p.m. RN)-B stated R27 can shave him. RN-B also stated it is with grooming as they can't in themselves and R27 is a very want him to have good	y			
	was walking down l	on 6/30/21, at 7:14 a.m. R27 hallway with front wheeled ed to have facial hair on face				
	stated R27 has der with shaving. NA-C attempted to shave was full of hair and clean it. NA-C state should be shaved of is a social man and	6/30/21, at 8:43 a.m. NA-C mentia and needs assistance further stated she had him this morning but his razon needed to find a brush to ed all men, if they prefer it, daily for appearance and R27 I it is important to him to have NA C further stated it	r			
	appeared R27 has	NA-C further stated it not been shaved for many k as he likes his hair short.				
	During interview on	6/30/21, at 10:35 a.m. the				

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00655	B. WING		06/30/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
APPLET	ON AREA HEALTH	30 S BEH APPLET	IL ST ON, MN 56208			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 920	director of nursing ( and women should growing and they pr further stated it is n be shaved. DON sta a dignity issue along can get caught in th Shaving the resider indicated "The purp promote cleanliness Notify the supervise procedure". Activities of Daily Li indicated "residents activities of daily livi the services necess grooming, and pers Care plan-Compreh expires 6/21, indica person-centered ca measurable objectiv resident's physical, needs is developed resident". SUGGESTED MET The director of nurs educate responsible residents' dependan residents' compreh DON or designee c dependent resident	(DON) stated that both men be shaved if they have hair refer it to be shaved. DON ot acceptable for men to not ated not being shaved can be g with harbor germs as food he hair. In policy revised 10/2010, pose of this procedure is to s and to provide skin care. For if the resident refuses the ving policy expires 6/21, s who are unable to carry out ing independently will receive sary to maintain good nutrition, sonal and oral hygiene". Thensive person-centered policy ted "A comprehensive, ire plan that includes ves and timetables to meet the psychosocial and functional and implemented for each THOD OF CORRECTION: sing and/or designee could e staff to provide care to int on facility staff, based on ensively assessed needs. The ould conduct audits of a cares to ensure their persona				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00655	B. WING		06/30/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
APPLET	ON AREA HEALTH	30 S BEH APPLETO	IL ST DN, MN 5620	08		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLET	
21015	Continued From pa	ge 31	21015			
21015	MN Rule 4658.0610 Requirements- Sar	) Subp. 7 Dietary Staff nitary conditi	21015		8/4/21	
	procedures and cor	conditions. Sanitary nditions must be maintained in dietary department at all				
	by: Based on observati review the facility fa the kitchen were pro	ent is not met as evidenced on, interview, and document illed to make sure the fans in operly cleaned and free of potential to affect all 43 lity.		Corrected.		
	Findings include:					
	thick dust/debris wa	on 6/28/21, at 10:29 a.m. as observed on black was blowing towards the ep counters.				
		6/28/21, at 10:29 a.m. cook-A nitary to have dust on fan, she ans it.				
	rep (assisting with of stated that she sees and further stated it blowing in the kitcho sanitary to be blowi areas. Staffing rep cleans the fan as sh	6/28/21, at 10:52 a.m. staffing dietary) observed the fan and s a lot of lint/debris on the fan was not ok for that fan to be en as it is a fire hazard and not ng the dust onto the serving stated she was unsure who he is not sure the facility if it was a staff members.				
	During interview on	6/29/21, at 4:08 a.m. the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00655	B. WING		06/30/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
APPLET	ON AREA HEALTH	30 S BEI APPLET	HL ST ON, MN 5620	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21015	Continued From pa	ge 32	21015			
		not acceptable to have a fan n dust in the kitchen, as it the food sources.				
	revised 9/2016, ind and control contam infection within the	n and control (Dietary) policy icated the purpose "To preven ination and the spread of dietary department" "All thoroughly cleaned after each				
	The dietary manage administrator, could control technique is The facility could up procedures, and ec and perform compe- registered dietician perform audits perio The facility should in Assurance Perform	THOD OF CORRECTION: er, registered dietician, or d ensure appropriate infection maintained in the kitchen. odate or create policies and lucate staff on these changes etencies. The dietary manager , or administrator could odically to ensure compliance. report audit findings to Quality ance Improvement (QAPI) for ations and to determine				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21620	MN Rule 4658.134	5 Labeling of Drugs	21620			8/4/21
	Drugs used in the r in accordance with	ursing home must be labeled part 6800.6300.				
	by:	ent is not met as evidenced				
	Based on observati	on, interview, and document		Corrected.		

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	00655		B. WING		06/30/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
APPLET	ON AREA HEALTH	30 S BEI APPLET	HL ST ON, MN 56208	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21620	Continued From pa	ige 33	21620			
	available for use in appropriately labele	ailed to ensure medications a medication cart were ad with an opened date in 2 of reviewed for medication				
	Findings include:					
		ated 6/30/21, indicated R40's dementia and glaucoma.				
	6/1/21-6/30/21, indi	dministration record (MAR) for icated R40 received scheduled spension 1% to both eyes two coma.	k			
	(LPN)-A and survey Suspension 1% we was no opened dat on the medication b	p.m., licensed practical nurse yor observed R40's Azopt re opened, in the cart. There e on the prescription label or pottle. According to the s medication was filled on				
	LPN-A stated it was is written on the phi bottles are first ope date the label is be expiration date and administered after to certain what the ex for Azopt but thoug for 28 days after the	medication cart inspection, s expected that an open date armacy label when eye drop and used. The reason to cause eye drops have an are not supposed to be that date. LPN-A was not piration date after opening was ht most eye drops were good ey were opened. LPN-A are no other opened bottles of for R40.	5			
	(PC)-A indicated ey	p.m. pharmacy consultant ve drops needed to be dated risk of bacterial growth				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00655	B. WING		06/30/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
APPLET	ON AREA HEALTH	30 S BEI APPLET	HL ST ON, MN 56208	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21620	Continued From pa	ge 34	21620			
	was opened. There infection if the eye of expiration date. PC should be stopped they are opened. On 6/30/21, at 2:00 stated she expected when opened. Unla unacceptable. Facility policy, Labe last revised 7/2019, label should include	er the bottle was used after it was an increased risk of drop was used after the -A stated Azopt eye drops no more than 28 days after p.m. director of nurse (DON) d eye drops were labeled ibeled eye drops were eling of Medication Containers, indicated the medication e the expiration date when not address the need to label open date.				
	The director of nurs develop and implem related to labeling e provide education to regarding the impor medications. The D periodic medication	THOD FOR CORRECTION: sing (DON) or designee could nent policies and procedures eye drops with open date and o staff who pass medications rtance of dating these DON or designee could do n cart audits to ensure eye neled with an open date.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			8/4/21
	residents have the	us treatment. Patients and right to be treated with ct for their individuality by				

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING			
		00655			06/30/2021	
		30 S BEH		STATE, ZIP CODE		
APPLET	ON AREA HEALTH	APPLET	ON, MN 562	08		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLE	
21805	Continued From pa	age 35	21805			
	employees of or pe health care facility.	rsons providing service in a				
	by: Based on observati review the facility fa	ent is not met as evidenced ion, interview, and record ailed to ensure 3 of 4 residents ) were provided a dignified		Corrected.		
	Findings include:					
		mum data set (MDS) dated noderate cognitive impairment ent with eating.				
		S dated 6/2/21, indicated apairment and needed ing.				
		nange MDS dated 4/19/21, ognitive impairment and n with eating.				
	unknown dietary aid and R18 were alrea Other residents in o	on 6/28/21, at 11:57 a.m. d brought R4 her meal. R40 ady sitting at table with R4. dining room being asked what s. No one asked R40 or R18 o eat.				
	R40 reached acros food. R4 stated "that	on 06/28/21, at 12:05 p.m. s table and took a bite of R4's at is mine". Other individuals oom receiving there meals				
	received her meal.	on 6/28/21, at 12:07 R40				
TE FOR	epartment of Health M		6899	O9ET11	If continuation sheet 36	

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00655	B. WING		06/30/2021	
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
	ON AREA HEALTH	30 S BEH	IL ST			
		APPLET	ON, MN 56208	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21805	Continued From pa	age 36	21805			
		on 6/28/21, at 12:11 p.m. 18 tray. Staff assisting with cutting table 1.				
	aide (DA)-A stated individuals at that s their meals at the s	n 6/29/21, at 12:44 p.m. dietary when passing out trays all same table should be delivered same time. DA-A stated it is not for residents to watch others eating.				
	medication aide (T passing meal trays be serving everyon moving to the next was not ok for one	n 6/29/21, at 12:55 p.m. train MA)-A stated when staff are in the dining room they should a at one table first before one. TMA-A further stated it resident to get food and the and watch that individual eat.				
	practical nurse (LP tag and then find th and ask them what further stated there the staff grab first. serving everyone a the next. LPN-B fur have one person s	h 6/29/21, at 1:30 p.m. licensed N)-B stated staff grab a name he resident in the dining room t they would like to eat. LPN-B e is no rhyme or reason to who LPN-B stated they should be tt the table before moving on to rther stated it is not right to erved first and then the others I-B stated if that was me "I				
	registered nurse (F has now changed t room. RN-A stated the processes in th indicated it is a dig	n 6/29/21, at 4:59 p.m. RN)-A stated the dining process to residents eating in the dining they need to work on some of the dining room. RN-A further nity issue when you have one sir meal and the others at the				

O9ET11

If continuation sheet 37 of 38

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		RECTION IDENTIFICATION NUMBER: A. BUILDING:					
	00655		B. WING		06/3	30/2021	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE			
APPLET	ON AREA HEALTH	30 S BEI APPLET	HL ST ON, MN 56208	3			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21805	Continued From pa	age 37	21805				
	director of nursing should be served o ok otherwise. DON someone eating in Requested policy fo	n 6/30/21, at 10:35 a.m. the (DON) stated all residents one table at a time and it is not further stated "I wouldn't want my face while I am waiting". or dining room procedure: no s. Facility did supply policy for eals expired 6/21.					
	The administrator, designee could dev care by the interdis residents dignity is could update policie staff on these chan resident(s) dignity a these audits will be assurance committ	THOD OF CORRECTION: director of nursing (DON), or velop and implement a plan of ciplinary team to ensure being maintained. The facility es and procedures, educate ages, and audit to ensure are maintained. The results of reviewed by the quality tee to ensure compliance. R CORRECTION: Twenty-one					
	epartment 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							APPROVED 0. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEI IDENTIFICATION NUM	R/CLIA	. ,	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE S COMPL	GURVEY
		245231		B. WING		07/1	3/2021
NAME OF F	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	TATE, ZIP CODE	•	
APPLET	ON AREA HEALTH		30 S BE APPLE	EHL ST TON, MN	56208		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE F BE PRECEDED BY FULL F INTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ΓS		K 000			
	FIRE SAFETY						
	conducted by the M Public Safety, State time of this survey, Home was found in requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National I (NFPA) Standard 1 Chapter 19 Existing (2012 edition) Heal	ety Code Survey was linnesota Departmer Fire Marshal Divisio Appleton Municipal la compliance with the articipation in at 42 CFR, Subpart ety from Fire, and the Fire Protection Assoc 01, Life Safety Code g Health Care and NI th Care Facilities Co Nursing Home is a 2	nt of on. At the Nursing 2012 ciation (LSC), FPA 99 de.				
	building with a no b constructed at 3 dif building was constr determined to be of 1976, an addition w determined to be of addition was added determined to be of Because the origina meet the constructi	pasement. The building ferent times. The origonated in 1964 and w f Type II(000) constru- vas added to the eas f Type II(222). In 199 I to the southeast that f Type II(000) constru- al building and the ac- on type allowed for a ing, the facility was s	ng was ginal as uction. In t that was 2 an at was uction. dditions a Type II				
	facility has a fire ala detection in the cor	sprinklered through arm system with smo ridors and spaces of nitored for automatic tion.	oke ben to the				
	The facility has a c census of 43 at the	apacity of 50 beds a time of the survey.	nd had a				
	•	42 CFR, Subpart 48	( )				
LABORATO	RY DIRECTOR'S OR PROV	<b>IDER/SUPPLIER REPRESE</b>	NTATIVE'S SIG	NATURE	TITLE		(X6) DATE

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

Printed: 07/23/2021

DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					APPROVED 0.0938-0391
STATEMENT OF DEFICIENCIES (X1)	PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	A (X2) MULTI	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE S COMPL	SURVEY
	245231	B. WING		07/1	3/2021
NAME OF PROVIDER OR SUPPLIER	STF	REET ADDRESS, CITY, S	STATE, ZIP CODE		
APPLETON AREA HEALTH		30 S BEHL ST APPLETON, MN	56208		
PRÉFIX (EACH DEFICIENCY MUST BE F	ENT OF DEFICIENCIES PRECEDED BY FULL REGU YING INFORMATION)	ID ILATORY PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
K 000 Continued From page MET.	1	К 000			

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

Printed: 07/23/2021