Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 20, 2023

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

RE: CCN: 245231
Cycle Start Date: January 26, 2023

Dear Administrator:

On February 15, 2023, we notified you a remedy was imposed. On March 10, 2023 the Minnesota Department(s) 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 March 10, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 17, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of February 15, 2023, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 16, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 10, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, 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,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 15, 2023

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

RE: CCN: 245231
Cycle Start Date: January 26, 2023

Dear Administrator:

On January 26, 2023, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

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(ies) 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 March 17, 2023.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 17, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 17, 2023.

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.

This Department is also recommending that CMS impose:

- 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.

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 $11,292; 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.

If you have not achieved substantial compliance by March 17, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Appleton Area Health will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 17, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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" and/or an "E" tag), i.e., the plan of correction should be directed to:

Judy Loecken, 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: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 - Health Regulation Division 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 July 26, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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

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:

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

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

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

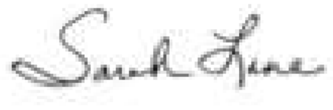
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245231	A. BUILDING _____ B. WING _____	01/26/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 1/23/23 through 1/26/23,a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1),	E 041		2/22/23

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

Electronically Signed | 02/22/2023

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

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E 041	Continued From page 1 §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the	E 041		

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E 041	Continued From page 2 material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..	E 041		

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E 041	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 101 (2012 edition), Life Safety Code, section 9.1.3.1, NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 through 8.4.2, and 8.4.2.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/24/2023 at 2:00 PM, it was revealed by a review of available emergency generator test, inspection documentation, and interview with the Director of Maintenance, that the facility could not provide documentation at the time of the survey for weekly emergency generator inspections for the weeks of 08/21/2022- 09/06/2022. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	E 041	1. EVS Manager, Butch Olson will ensure weekly generator inspections are completed and required documentation is filed appropriately. The inspections are completed weekly. 2. All current residents have the potential to be affected by stated deficiency, no similar findings and/or negative effects have been identified. 3. To ensure compliance with weekly inspections the LNHA, DON or Designee will audit weekly inspection documentation 1x/week for 2 weeks, 2x/month for 1 month, 1x/month for 3 months. Survey results and audit results will be brought to the quarterly QAPI committee for review and action, as appropriate. The QAPI committee will determine the need for further audits.	

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F 000	INITIAL COMMENTS On 1/23/23 through1/26/2023, a standard recertification survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other	F 609		3/3/23

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

Electronically Signed | 02/22/2023

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

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F 609	Continued From page 1 officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to immediately report an allegation of abuse within the required 2 hours to the State Agency for one of one residents (R11) when R11 reported staff to resident verbal abuse. Findings Include: R11's significant change Minimum Data Set (MDS) dated 1/19/23, indicated intact cognition based on Brief Interview for Mental Status (BIMS) score of 13/15. R11 was frequently incontinent of bowel and bladder and required assist of two staff for bed mobility, transfers, dressing, bathroom needs, and personal hygiene. R11's care plan indicated resident's vulnerability potential due to her physical status, complex medical condition, and dependence on two staff for activities of daily living (ADLs). It stated resident will receive needed care in manner that provides her safety and dignity for her over all well-being.	F 609	1.It is the policy of this facility that all residents will be free from abuse, neglect, maltreatment, and misappropriation of resident property to abide by state and federal regulations. Ensuring all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The facility failed to immediately report an allegation of abuse within the 2 hours to the state agency for resident R11 when R11 reported staff to resident abuse to state surveyor on 1/23/23 at 5:15pm. State Surveyor reported to facility on 1/23/23 at 7:45pm the allegation of verbal threat to deny cares. NA-A was	

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F 609	Continued From page 2 During an interview on 1/23/23, at 5:15 p.m. R11 stated nursing assistant (NA-A) refused to help her that morning because she didn't say "please". R11 stated she'd to "take it higher". NA-A provided cares, however, stated "I can walk out of here any time I want to." R11 did not report this to the facility, however, stated it made her feel "very inferior". On 1/23/23, at 7:45 p.m. allegation of verbal threat to deny cares was reported by surveyor to the director of nursing (DON) and administrator. During an interview on 1/24/23, at 10:48 a.m. DON stated suspected abuse, was reported to OHFC (office for health facility complaints) and suspected abuser was removed until investigation was complete. However, there was no evidence this incident had been reported to the SA. During an interview on 1/25/23, at 2:03 p.m. DON and administrator stated after an internal investigation, the facility removed the NA-A from the schedule and planned to make a report to the state agency. Further, they acknowledged the report was late and should have been reported within two hours of initial report from R11. NA-A's employee file indicated EduCare training modules titled "Abuse Prevention", and "Abuse Prevention and Resident Rights" were completed on 7/1/20. NA-As Minnesota Nursing Assistant Registry verified. Expires12/9/23. Background clearance completed for NA-A on 1/29/22. Review of Abuse, Neglect, Mistreatment and Misappropriation of Property policy, last revised 1/7/2021, indicated allegations of abuse were to be reported to the SA within 2 hours.	F 609	immediately removed from care of R11. The interdisciplinary team discussed the allegation after internal investigation was completed with a determination to file the abuse allegation to state agency on 1/25/23 at 7:09pm. With information gathered from internal investigation the 5 day follow up report was submitted 1/25/23 at 7:30pm. Surveyors were in the building during annual survey, investigated the allegation at the same time the facility was completing the internal investigation. 2.All current residents have potential to be affected by stated deficiency; no similar findings and/or negative effects have been identified by this alleged deficient practice. 3.To enhance currently compliant reporting requirements under the direction of the Director of Nursing a. The Interdisciplinary Team and Care Center Nursing staff were educated on the requirements of F609, Reporting of Alleged Violations at a staff meeting on February 6th and 7th, 2023 with a post-test requirement of 80% to pass or retake until 80% correct is achieved. As of 2/20/23 40% have completed the education and passed the post-test requirement. b. The education focused on the facility's responsibility to ensure alleged violations involving abuse, neglect, maltreatment, and misappropriation of resident property are immediately reported to the Nurse, Administrator, DON and/or Social Services Coordinator and respective State Agency as indicated in timely manner.	

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F 609	Continued From page 3	F 609	c. All care center nursing staff that did not attend the staff meeting will have 100% compliance by 3/3/23. d. All new hires will be educated by LNHA, DON or designee by use of a handout and review of the policy. After completion, staff will have to pass a written competency exam with 80% correct. If 80% is not achieved, the employee will have to review the information again, with repeat competency examination, until 80% correct is achieved. Annual education to be completed by Social Services Coordinator or designee and Health stream required annual training. e. Residents' right bingo will be completed by activities monthly to ensure that residents are aware of their rights. Resident Rights are reviewed at resident/family council by Social Services Coordinator. 4. Interdisciplinary team under the direction of the Director of Nursing will review falls, incidents, and reports of suspected abuse at morning stand up and track if any of the incidents were reportable, if they were reported, and if reported in a timely manner. Findings will be brought to QAPI committee for review and action, as appropriate. The QAPI committee will determine the need for further action plan.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		3/3/23

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F 880	Continued From page 4 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 880		

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F 880	Continued From page 5 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure infection control practices were followed during handling of soiled laundry. This had the potential to affect all residents whose laundry was completed at the facility. Findings include: During observation on 1/26/23, at 8:27 a.m. laundry aide (LA)-A did not have on proper PPE when sorting soiled laundry. During interview on 1/26/23, at 8:27 a.m. LA-A stated gowns were not worn over clothing to sort	F 880	1.It is the policy of this facility to abide by state and federal regulations related to maintain an infection prevention and control program designed for a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The policy labeled Departmental (Environmental Services) □ Laundry and Linen states that employees sorting or washing linen must wear a gown and gloves to cover their arms and clothing while sorting dirty laundry. Laundry aides stated that they wear gowns with different colored bags.	

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F 880	Continued From page 6 soiled laundry items, unless the bag was a different color. However, gloves were worn at all times when sorting laundry. LA-A stated she was not aware of the need to wear a gown while sorting soiled laundry. An interview on 1/26/23, at 10:14 a.m. infection preventionist (IP) stated staff were expected to wear gowns and gloves when sorting laundry. However, "I cannot confirm the laundry staff are wearing gowns downstairs when sorting laundry". Further, nurse aides likely did not wear a gown when they sorted laundry items either. The facility policy Departmental (Environmental Services)-Laundry and Linen approve date 1/26/23, indicated employees sorting or washing line must wear a gown and gloves. A mask may be worn if aerosolization is expected. Use heavy duty rubber gloves for sorting laundry. Always wash hands after completing the task and removing gloves.	F 880	Laundry aides we educated on the policy immediately on 1/26/2023 and provided with washable gowns to be worn while sorting dirty linens by Environmental Services Manager Butch Olson and Infection Preventionist Manager Beth Taylor, RN. The policy will be easily available to reference by hanging in the laundry area and soiled utility rooms completed on 2/16/2023. No residents were negatively affected by the cited deficiency. 2.All residents have the potential to be affected by the cited deficiency related to the deficient practice during sorting of soiled laundry as laundry is sorted in one main laundry room for the entire care center. 3.To enhance the Care Center infection control program and under the direction of the Director of Nursing, and Infection Preventionist, the interdisciplinary team completed an RCA on 2/13/2023 that identified cause of the cited deficiency. In addition to the following: a.The policy labeled Departmental (Environmental Services) □ Laundry and Linen states that employees sorting or washing linen must wear a gown and gloves to cover their arms and clothing while sorting dirty laundry. This policy was reviewed, and updated by Kris Payne, RN/DON on 2/16/2023 to replace the statement use heavy duty rubber gloves for sorting laundry with use rubber gloves for sorting laundry. Always wash hands after completing the task and removing gloves. b.Laundry, ENVS, and all care center	

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F 880	Continued From page 7	F 880	nursing staff will be educated on the policy and procedure updates with completion date by 3/3/2023, with 100% compliance. c.Education will be provided by Beth Taylor, RN Infection Preventionist manager by live presentation and use of power point slides. After completion, staff will have to pass a written competency exam with 80% correct. If 80% is not achieved, the employee will have to complete the presentation again, with repeat competency examination, until 80% correct is achieved. d.Record of education completion will be kept in DON office in POC 2023 binder. 4.Director of Nursing, Infection Preventionist, Environmental Services Manager or designee will audit proper PPE while sorting laundry at random times throughout their shift 5x/week x 2 week, 3x/week x 2 week, 2x/week x 2 week, 1x/week x 2 weeks. Survey results and audit results will be brought to the QAPI committee for review and action, as appropriate. The QAPI committee will determine the need for further audits and/or action plan.	

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Appleton Area Health was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/22/2023

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

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K 000	Continued From page 1 State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Appleton Area Health is a 2-story building with a no basement. The building was constructed at 3 different times. The original building was constructed in 1964 and was determined to be of Type II (000) construction. In 1976, an addition was added to the east that was determined to be of Type II (222). In 1992 an addition was added to the southeast that was determined to be of Type II (000) construction. Because the original building and the additions meet the construction type allowed for a Type II (000) existing building, the facility was surveyed as one building.	K 000		

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K 000	Continued From page 2 The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 47 beds and had a census of 44 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.5 and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, section 14.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 345	EVS Manager, Butch Olson, and the Maintenance department will complete the semi-annual fire alarm inspections. EVS Manager, Butch Olson to ensure appropriate documentation is available at time of inspection. Semi-annual inspection completed 3/10/23. Data will be presented at April QAPI meeting.	3/10/23

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K 345	Continued From page 3 On 01/24/2023 at 12:30 PM, it was revealed by a review of available documentation that the semi-annual fire alarm testing documentation was not available at the time of the survey. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 345		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12 . This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/24/2023 at 12:45 PM, it was revealed by a review of available documentation at the time of the survey the facility could not provide a damper	K 521	EVS Manager, Butch Olson will contract with a third-party vendor to have a damper inspection and testing done at least every 4 years. Findings from the inspection and testing will be presented at the following quarterly QAPI meeting. G&R Controls was contracted and completed HVAC damper inspection and testing on 02/09/23.	2/9/23

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K 521	Continued From page 4 inspection and testing report that includes the location of the damper, date of inspection, name of inspector, and deficiencies discovered, that was completed within the last four years. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 521		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/24/2023 at 1:00 PM, it was revealed by a review of available documentation that the facility did not perform a fire drill in the care facility during second shift of the second quarter, all	K 712	EVS Manager, Butch Olson, or designee will be responsible for conducting required fire drills every shift, every quarter for the facility. EVS Manager, Butch Olson, or designee will ensure all drill paperwork has required signatures of participating staff. The hard copy will be filed in the survey binder. Completed fire drills will continue to be discussed at quarterly Safety and QAPI meetings. EVS Manager, Butch Olson Located support for Q2 2nd shift and Q3 all shifts, documents were emailed to surveyor on	1/25/23

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K 712	Continued From page 5 shifts in the 3rd quarter and the second shift of the 4th quarter of 2022. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 712	01/25/2023.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to complete a Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/24/2023 at 1:30 PM, it was revealed by a review of available documentation that the facility could not provide documentation showing that they have completed an NFPA 99 Risk Assessment for the facility at the time of the survey.	K 901	EVS Manager, Butch Olson will ensure that he is able to provide the Risk Assessment at point of inspection. Risk assessment is completed annually as well as updates as needed throughout the year. Located NPFA 99 Risk Assessment was submitted via email to the surveyor on 01/24/2023.	1/24/23

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K 901	Continued From page 6 An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 901		
K 918 SS=C	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.	K 918		2/22/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245231	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/24/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 7 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 101 (2012 edition), Life Safety Code, section 9.1.3.1, NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 through 8.4.2, and 8.4.2.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/24/2023 at 2:00 PM, it was revealed by a review of available emergency generator test and inspection documentation and an interview with the Director of Maintenance, that the facility could not provide documentation at the time of the survey for weekly emergency generator inspections for the weeks of 08/21/2022-09/06/2022. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K 918	EVS Manager, Butch Olson will ensure weekly generator inspections are completed and required documentation is filed appropriately. The inspections are completed weekly. To ensure compliance with weekly inspections the LNHA, DON or Designee will audit weekly inspection documentation 1x/week for 2 weeks, 2x/month for 1 month, 1x/month for 3 months. Survey results and audit results will be brought to the QAPI committee for review and action, as appropriate. The QAPI committee will determine the need for further audits.	