Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 22, 2023

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

RE: CCN: 245231
Cycle Start Date: November 1, 2023

Dear Administrator:

On November 15, 2023, we informed you that we may impose enforcement remedies.

On November 8, 2023, the Minnesota Department(s) of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby 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:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 1, 2024

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 1, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 1, 2024.

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 a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

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 $11,995, 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 February 1, 2024, 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 February 1, 2024. 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 May 1, 2024 (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 § 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
202-795-7490

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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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	245231	A. BUILDING _____ B. WING _____	C 11/08/2023

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

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E 000	Initial Comments On 11/6/23 through 11/8/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 11/6/23 through 11/8/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H52317022C (MN98261). 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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		12/29/23

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

Electronically Signed | 12/02/2023

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 656	Continued From page 1 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		

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F 656	Continued From page 2 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the comprehensive care plan with individualized communication intervention for 1 of 1 (R19) resident reviewed. Findings include: R19's 11/7/23, admission record identified diagnoses of hemiplegia (paralysis of one side of body) following a stroke, dysphasia (difficulty speaking) and dysphagia (difficulty swallowing). R19's 10/3/23, revised care plan identified a communication deficit as R19 was from Micronesia and only understanding simple words of English. Staff were to get R19's attention by making eye contact, and show or point in direction R19 was going to roll in bed. R19 was able to indicate "yes" or "no" by shaking her head in that gesture. R19 preferred to communicate in Micronesian. The facility was to provide a translator as necessary to communicate with resident. The translator was identified as a family member (FM)-A. Staff may call the FM-A or face time FM-A to translate. There was no mention of how the staff would communicate if they were unable to contact FM-A. There was no mention of alternate translation options if needed.	F 656	1.It is the policy of this facility to create an individualized comprehensive care plan for every resident. The facility failed to revise the comprehensive care plan with individualized communication interventions (R19). R19's 10/3/23, revised care plan identified a communication deficit as R19 was from Micronesia and only understanding simple words of English. Staff were to get R19's attention by making eye contact and show or point in direction R19 was going to roll in bed. R19 was able to indicate "yes" or "no" by shaking her head in that gesture. R19 preferred to communicate in Micronesian. The facility was to provide a translator as necessary to communicate with resident. The translator was identified as a family member (FM)-A. Staff may call the FM-A or face time FM-A to translate. There was no mention of how the staff would communicate if they were unable to contact communicate if they were unable to contact. This facility is in a rural area with limited options for certified translation services for the Micronesia population. 2.All residents with limited English proficiency have potential to be affected by stated deficiency; 1 similar current	

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F 656	Continued From page 3 R19's 1/11/23, Care Area Assessment related to communication identified R19's primary language was Micronesian. R19 understood simple English phrases and could answer "yes" or "no". The interdisciplinary team had determined R19 had a communication problem as evidenced by hesitation and need to repeat or rephrase a statement. R19's primary language was Micronesian with FM-A providing interpretation. R19's communication difficulties could result in social isolation, depression, and/or safety concerns. Observation on 11/6/23 at 12:30 p.m., of R19 in her bed awake with television on identified when addressing R19 after saying "hello, how are you?", R19 looked but had not responded. Interview on 11/6/23 at 12:51 p.m., with nursing assistant (NA)-A identified R19 knew "very little" English but could communicate "yes" or "no". R19 did not have a communication board that she was aware of to assist with her communication. Interview on 11/6/23 at 12:58 p.m., with trained medication aide (TMA)-A reported R19 communicated her pain by a number system or R19 would "blink" if she had pain when asked. TMA-A reported that R19 had been at the facility for a long time and staff just "knew" her routine. She identified R19 had family members who worked at the facility, and they would translate. Interview on 11/6/23 at 2:45 p.m., with FM-A and FM-B who reported that the facility will call a family member if they could not figure out what R19 needed, and the family was okay with that. FM-B revealed it would be a good idea to have another translator as a backup though. FM-A	F 656	resident has been identified by this alleged deficient practice. 3.To enhance currently compliant services and documentation requirements under the direction of the Director of Nursing: a.Social Services Coordinator will be responsible for organizing with Cyracom Interpretation Services for all current residents with limited English proficiency to obtain written or verbal consent to utilize family/employees for translation services as first choice translation services, permission to share PHI with those family members/employees, and if Cyracom Interpretation Services are not able to provide the language requested may utilize family/employees for translation services. b.Social Services Coordinator will be responsible for organizing with Cyracom Interpretation Services for all new admissions with limited English proficiency to obtain written or verbal consent to utilize family/employees for translation services as first choice translation services, permission to share PHI with those family members/employees, and if Cyracom Interpretation Services are not able to provide the language requested may utilize family/employees for translation services. c.MDS Coordinators will update care plans to reflect preferred communication/translation services. If residents give family/employees permission to utilize as translation services, Cyracom Interpretation Services	

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F 656	Continued From page 4 confirmed that R19 did not have a communication board. R19's 11/2/23, progress note at 2:40 p.m. identified the facility had been unable to contact FM-A and FM-B to update about R19's new orders, the note indicated the facility would continue to attempt to contact. Additional progress notes on 11/2/23 at 4:14 p.m., facility unable to contact FM-A or FM-B facility will continue to attempt to reach. Interview on 11/7/23 at 9:25 a.m., with social service designee (SSD) identified R19 spoke minimal English but could communicate cares. The facility used family when they needed to communicate in more detail. SSD revealed there was a translation service number located in the emergency room that connected to a television for translation that she thought the facility could use if needed. The SSD then reported during the daytime hours the facility had translation "covered" as there were family members who worked at the facility. The SSD was unsure if R19 had ever had an assessment for a need for a translator. She reported that she had tried Google translate before, however, that does not translate from English to Chuukese or visa versa when talking as the language is very specific to certain regions in Micronesia. The SSD confirmed all translation was done by family and if the facility was unable to reach family, they could "potentially" use the number located in the attached hospital ER room. Interview on 11/7/23 at 9:39 a.m., with the director of nursing (DON) identified R19 spoke in Chuukese her primary language. The DON reported the facility had a staff member that had	F 656	will be utilized as back up if first choice is unavailable and will be stated in care plan. d.Social Services Coordinator or designee will contact Cyracom Interpretation Services to schedule interpretation services for all planned care conferences and appointments for translation services. e.Communication board will be created and placed in residents room to aide in communication with staff along with Cyracom Interpretation Services information. f.Care Plan and Translation/Interpretation policies will be updated to reflect requirements. 4. Director of Nursing, Social Services Coordinator or Designee will audit completion progress of updated care plans, consents, communication board and updated policies 1x/week for 4 weeks to ensure compliance with plan of correction of completion date 12/29/2023. Results of these audits will be brought to QAPI committee to determine compliance or the need for further monitoring.	

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F 656	Continued From page 5 created signs of COVID and admission questions in Chuukese however, the facility still needed an interpreter to translate that information once asked. The DON revealed the clinic had a receptionist that was a paid translator for the hospital and the nursing home that the facility could use if needed. She confirmed R19's care plan lacked identification of any back up translation services the facility could use if family was unavailable, which she confirmed did occur at times. The DON confirmed that there was a "real struggle" to communicate with R19. She further confirmed the facility should have an alternate translator option available and identified on the care plan. There should be direction noted for staff if the facility was unable to reach the family to translate. Additional interview on 11/8/23 at 1:17 p.m., with the DON identified that the "care plans were not updated like they should be". Her expectation was all residents care plans should reflect their current level of care and were individualized. Review of 11/6/23, Translation and/or Interpretation policy identified when an individual with limited English proficiency would have an initial language assessment completed. All residents with limited English would receive a written notice in their primary language of their rights to obtain an oral translation service free of charge. The interpreters and translators must be appropriately trained in medical terminology, confidentiality, and ethical issues that may arise. Family members and friends shall not be relied upon to provide translation services unless explicitly requested by the resident. If friends or family are used to interpret the resident must provide written consent for disclosure of protected health information.	F 656		

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F 656	Continued From page 6 Review of 11/7/23, Care Plans-Comprehensive Person-Centered policy identified a resident would have a comprehensive individualized care plan developed and implemented to meet the residents needs. The care plan was to include the residents cultural and personal preference and describe specialized services needed to enhance optimal functioning of the resident. The comprehensive person-centered care plans were to be reviewed and updated to reflect the residents needs or condition changes.	F 656		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced	F 700		12/29/23

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F 700	Continued From page 7 by: Based on observation, interview and document review, the facility failed to comprehensively assess and obtain informed consent, prior to resident use of bed rails for 1 of 1 resident (R23) reviewed for bed rail use. Findings include: R23's 8/31/23, annual Minimum Data Set (MDS) assessment identified R23's cognition was intact, R23 required moderate to substantial assistance with personal hygiene. R23 required supervision to get from a lying to sitting position on the bed and R23 was able to stand independently from a sitting position. R23 was identified in section P of the MDS as having no bed rails used. R23's undated, care plan identified R23 used a lift chair recliner to maximize independence with repositioning. Occupational therapy has assessed R23's use of the lift chair for safety. Staff were to respect R23's right to sleep in his recliner if choosing not to sleep in the bed. There was no mention of the bilateral 1/2 side rails on R23's bed. R23's 6/1/23, Safety Risk Assessment identified history of low back pain currently controlled with spinal stimulator. R23 had urge incontinence, and a recent room change that R23 reported he liked and was adjusting well to with no issues noted. R23 had bed, side table, recliner, walker, and wheelchair. R23 had a lift chair and was able to show appropriate ability to move from a lying to sitting position. R23 was able to get from a sitting to standing position. R23 was able to ambulate the length of the hallway without difficulty. R23's walker and call light kept within reach. There	F 700	1.It is the policy of this facility to identify and reduce safety risks and hazards commonly associated with bed rail use. A duo-faceted approach will be used to achieve sustainable quality outcomes, including 1) regular bed maintenance and 2) individual bed rail evaluations. In response to the requirement of providing for a "safe, clean, comfortable, and homelike environment," the facility's regular maintenance program will include regular inspection of all bed systems (e.g. rails, frames, and mattresses, and operational components) to ensure they are clean, comfortable, and safe. The facility will also ensure individual resident bed rail evaluations are performed on a regular basis. Individual bed rail evaluations will include data collection analysis and determination of potential alternatives to bed rail use. When bed rail(s) are deemed necessary and appropriate, the facility will provide education to resident or resident's representative pertaining to the risk and benefits of bed rail use. The facility's priority is to ensure safe and appropriate bed rail use. The facility failed to comprehensively assess and obtain informed consent, prior to resident use of bed rails for 1 of 1 resident (R23). R23's 8/31/23, annual Minimum Data Set (MDS) assessment identified R23's cognition was intact, R23 required moderate to substantial assistance with personal hygiene. R23 required supervision to get from a lying to sitting position on the bed and R23 was able to stand independently	

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F 700	Continued From page 8 were no mention of 1/2 side rails on the bed. R23's 8/31/23, Safety risk assessment identified 2 falls in past year however none in last quarter. Physical therapy orders were obtained however, R23 refused to work with therapy. R23 had a riser over the toilet with handles to help with getting on and off toilet. R23's cognition was intact and R23 kept his walker within reach. There was no mention of R23 having or using 1/2 side rails on his bed for mobility. Interview on 11/8/23 at 11:19 a.m., with R23 who reported he sleeps in his bed, and he uses the side rails to pull himself up to a sitting position and maybe he used them when he turns around in bed, but he could not remember. Interview on 11/8/23 at 12:31 p.m., with maintenance supervisor (MS) identified the nurse's let maintenance know if there was a loose side rail or something and then they would go assess and fix that. He confirmed that maintenance did not complete any type of routine checks on the bed rails for safety in the facility. The direct care staff work with the residents in their rooms daily and they would be the ones to notice if something needed to be repaired and then notify maintenance. Interview on 11/8/23 at 11:25 a.m., with director of nursing (DON) identified R23 had moved to his current room on 5/24/23, and the bed was already in the room so the 1/2 side rails must have been already on the bed when R23 moved in. The DON confirmed that the 1/2 side rails were not identified on his safety risk assessment, not on his care plan, and there was no side rail assessment completed as they were not aware R23 even had the bed rails on his bed. She	F 700	from a sitting position. R23 was identified in section P of the MDS as having no bed rails used. R23 recently had a room change, the bed in new room had bed rails and was not assessed for appropriateness of bed rails. 2.All residents have the 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 assessment and documentation requirements under the direction of the Director of Nursing: a.MDS Care Coordinator immediately assessed R23 resident for bed rail safety. b.The Interdisciplinary Team will review all current resident beds for bed rails, i.If bed rails; will review medical charts to ensure safety assessment and consents are completed on those. ii.If not; MDS care coordinator will complete the safety assessment and consents or have bed rail(s) removed if not appropriate. c.To ensure bed rails are used appropriately and assessed for continued need of bed rail(s); MDS care coordinators will be required to visualize residents' bed for bed rail(s), verify bed rail(s) use is indicated on care plan, verify initial consent was obtained, and complete the physical device data collection form quarterly with MDS ARD's. d.All new admissions MDS care coordinators will assess resident for the	

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F 700	Continued From page 9 reported prior to R23's move to his current room he did not have side rails on his bed and when the nurse completed his assessment, they must have missed that. Additional interview at 1:17 p.m., with the DON who identified her expectation was that any resident with a bed rail or grab bar would have an assessment completed and the care plan would reflect the assessment. Review of 1/6/21, Bed Rail policy identified goal to reduce safety risks and hazards commonly associated with bed rail use and prevent entrapment. The facility will complete regular bed maintenance to inspect all bed systems are operational and ensure they are safe. Residents using bed rails will have bed rail evaluation to determine alternatives to bed rail use. Education to resident pertaining to the risk and benefits of bed rail use will be provided. The bed rail policy was used to determine if the resident was safe and able to use the bed rail. The interdisciplinary team would use data collected from regular bed inspections and individual bed rail assessments to care plan for positive outcomes. Ther was no indication the policy had been reviewed and updated annually per the regulation.	F 700	need of bed rail(s), indicate the use of bed rail(s) on care plan, obtain consent, and complete the physical device data collection form then complete the requirements for use of bed rail(s) quarterly with MDS ARD's. e.The Bed Rail(s) policy to be updated and reviewed at the next QAPI meeting in January. 4.Director of Nursing or Designee will randomly audit resident rooms for bed rail(s); if bed rail(s) are noted, will review medical chart for completion of safety assessment and/or physical device data collection form, and consent 1x/month for 3 months, then discuss findings at QAPI to determine the need for further audits.	
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the	F 868		12/29/23

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F 868	Continued From page 10 administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure 1 of 1 required member (infection preventionist) and/or their designee attended and documented the attendance at the quarterly Quality Assurance Performance Improvement (QAPI) meetings. Findings include: Review of the January 2023, through July 2023, quarterly Quality Assurance and Performance	F 868	1.The facility failed to ensure 1 of 1 required member (infection preventionist) and/or their designee attended and documented the attendance at the quarterly Quality Assurance Performance Improvement (QAPI) meetings. Review of the January 2023, through July 2023, quarterly Quality Assurance and Performance Improvement (QAPI) meeting minutes attendance record did not identify the facility infection	

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F 868	Continued From page 11 Improvement (QAPI) meeting minutes attendance record did not identify the facility infection preventionist was present at the second quarter meeting held in April 2023. Interview on 11/7/23 at 3:48 p.m., with the infection preventionist (IP) identified he was an interim IP who was to be responsible for covering the IP role until the new infection preventionist started. He confirmed he had not attended any of the QAPI meeting but he should be while covering the position. Interview on 11/8/23 at 8:25 a.m., with the director of nursing (DON) identified the IP could not make it to the April meeting. Normally, if the IP could not make it, they would delegate someone to cover the information and that was to be documented in the meeting minutes. The DON confirmed her expectation was the required QAPI members including the IP attended the quarterly meetings unless arrangements were made for someone else to cover for her. Review of the undated, QAPI plan identified all department managers, and infection control staff will be involved in the quarterly meetings. The departments will share findings with the medical staff and the board of directors. The policy had no mention of the required committee members such as the administrator or medical director that would be required to be identified and participate in the committee's quarterly meeting.	F 868	preventionist was present at the second quarter meeting held in April 2023. 2.All residents have the 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 meeting and documentation requirements under the direction of the Director of Nursing: a.The QAPI policy will be updated and reviewed at the January 2024 QAPI meeting. The policy will include, This facility will maintain a quality assessment and assurance committee consisting at a minimum of: i.The director of nursing services ii.The Medical Director or designee iii.At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role. iv.The infection preventionist; if the IP is unable to attend QAPI meeting the IP must delegate one of the required attendees to review the data prepared by IP. v.QAPI committee will have oversight during meetings to ensure the IP or designee is there, and take credit if someone is missing by notating that person was the designee. 4.Director of Nursing, Social Services Coordinator or Designee will audit	

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F 868	Continued From page 12	F 868	completion of updated policy 1x/week for 4 weeks to ensure compliance with plan of correction of completion date 12/29/2023.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §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	F 880		12/20/23

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F 880	Continued From page 13 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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 interview and document review, the facility failed to act on a positive tuberculosis (TB) test result for 1 of 5 staff (housekeeping (HSK)-A) tested for active TB upon hire. Furthermore, the facility failed to ensure any person or persons	F 880	1. It is the policy if this facility that all employees shall be screened for tuberculosis (TB) infection and disease, using a two-step tuberculin skin test (TST) or blood assay for Mycobacterium	

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F 880	Continued From page 14 with a positive history of TB was added to surveillance to mitigate potential risks for spread of possible active TB. This had the potential to affect all 43 residents, other staff, and visitors. Findings include: Review of housekeep (H)-A's employee file identified on 3/15/23, H-A's baseline TB Screening and questionnaire identified H-A had no symptoms of active TB however, it was identified that H-A had lived in Micronesia, and it was unknown if Micronesia had a high TB rate. Review of the National Library of Medicine (NIH) website, located at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3000724, identified the Federated States of Micronesia is a US-affiliated jurisdiction that comprises more than 600 islands dotted across 1 million square miles in the western Pacific Ocean. Micronesia is a low-income country where 27% of the people live below the US poverty line. While TB incidence in the United States continues to drop (4.4 reported cases per 100 000 population in 2007), Micronesia has sustained some of the highest rates of TB among the US-affiliated Pacific Islands (169 reported cases per 100 000 in 2008). Further review of H-A's Baseline TB Screening Tool for Healthcare Workers, identified H-A's hire date was 3/27/23. The form identified questions related to symptoms of active TB which were to be circled if present. The answer was listed as "none". The screening form noted if TB symptoms were present staff would promptly be referred for a chest X-ray and medical evaluation prior to working. The screening form further had	F 880	tuberculosis (BAMT) and symptom screening, prior to beginning employment. If positive, will be referred for a chest x-ray and medical evaluation. The need for annual testing shall be determined by the annual TB risk classification or as per State regulations. The facility failed to act on a positive tuberculosis (TB) test result for 1 of 5 staff (housekeeping (HSK)-A) tested for active TB upon hire. Furthermore, the facility failed to ensure any person or persons with a positive history of TB was added to surveillance to mitigate potential risks for spread of possible active TB. This had the potential to affect all 43 residents, other staff, and visitors. Review of (HSK)-A's employee file identified on 3/15/23, (HSK)-A's baseline TB Screening and questionnaire identified (HSK)-A had no symptoms of active TB however, it was identified that (HSK)-A had lived in Micronesia, and it was unknown if Micronesia had a high TB rate. Review of the National Library of Medicine (NIH) website, located at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3000724 identified the Federated States of Micronesia is a US-affiliated jurisdiction that comprises more than 600 islands dotted across 1 million square miles in the western Pacific Ocean. Micronesia is a low-income country where 27% of the people live below the US poverty line. While TB incidence in the United States continues to drop (4.4 reported cases per 100 000 population in 2007), Micronesia has sustained some of the highest rates of TB among the US-affiliated Pacific Islands (169 reported	

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F 880	Continued From page 15 questions about staff's personal history such as if the employee had ever had a positive test result, which was answered "no" on H-A's form. There was also a question asking if the staff had been a temporary or permanent residence in a country with a high TB rate for a month or longer (any country other than the United States, Canada, Australia, New Zealand, and those in Northern Europe or Western Europe). The answer was "yes", with a note next to the answer "if Micronesia counts". All other questions on the screening form to determine if active TB or symptoms of TB were present were answered as "no". Review of H-A's QuantiFERON-TB Gold Result identified as abnormal. The QuantiFERON-TB Gold test was completed on 3/17/23, with the results verified on 3/19/23 as "positive". "Interferon-gamma response to M. tuberculosis antigens detected, suggesting infection with M. tuberculosis. Positive results in staff at low risk for tuberculosis should be interpreted with caution and repeat testing should be considered as recommended". There was no indication test results were repeated for accuracy. Review of March through November 2023, resident infection and illness surveillance log had no evidence of residents with signs or symptoms of active TB and the staff infection and illness surveillance log had no evidence that H-A had ever called in to report any illness. The surveillance lacked identification of increased surveillance for H-A who had a known positive TB test result for signs or symptoms of active TB, that would have put all 43 residents at risk. Interview on 11/7/23 at 3:48 p.m., with infection	F 880	cases per 100 000 in 2008). Review of March through November 2023, resident infection, and illness surveillance log had no evidence of residents with signs or symptoms of active TB and the staff infection and illness surveillance log had no evidence that HSK-A had ever called in to report any illness. The surveillance lacked identification of increased surveillance for HSK-A who had a known positive TB test result for signs or symptoms of active TB, that would have put all 43 residents at risk. 2. All residents have the 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 new hire screening requirements under the direction of the Director of Nursing: a.The Tuberculosis- Employee Screening Policy will be updated and reviewed at the January 2024 QAPI meeting for approval or changes needed. b.The Baseline TB Screening form has been updated so questions are easier to understand. c.Director of Ancillary Services/Current Infection Preventionist updated Quantiferon Laboratory result to be identified as a Critical Lab Result both Human Resources and Infection Preventionist will be notified via in person or by phone of critical result and the employee will not be able to start working until chest x-ray and medical evaluation to	

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F 880	Continued From page 16 preventionist (IP) identified that he was not aware of H-A's positive TB test result until H-A's information was requested as part of the sample of staff to be reviewed for TB screening and testing. He reported "the minute" he reviewed the test results and saw H-A's positive result, he immediately sent H-A for a medical exam and chest X-ray. He was unsure why the previous IP had not acted upon the positive results. He confirmed he reviewed all the resident surveillance and found no residents to have had signs or symptoms of active TB since H-A started working. He further confirmed staff were not to start employment until a TB negative result was obtained per the facility policy and was the facility policy to not hire any staff with an active TB test. Review of H-A's 11/7/23, Chest X-ray result were negative. There was no physician progress note to review related to the medical examination portion. Interview on 11/8/23 at 1:17 p.m., with director on nursing (DON) identified she was unaware H-A had a positive TB test result on 3/19/23. The DON reported the IP was responsible for ensuring new hires were screened and had laboratory testing for active TB and found positive, they were to be sent for a medical exam and/or chest X-ray with a physician. The IP was responsible to act on any positive TB results and file the results in the staff personnel file. The previous IP ended her employment on 8/1/23. H-A was employed full time and had never called in for work since starting her employment. Staff were not allowed to work at the facility if a staff was shown positive until they had a repeat test showing it was truly negative.	F 880	rule out active TB symptoms indicate safe to work. Policy to reflect this plan as well. d.TB education for Care Center Nursing Staff at December 2023 Nurse/CNA Meetings. e.All staff are required to complete annual education on Tuberculosis control, prevention, and treatment. The module reviews the causes of TB, risk factors, symptoms, transmission, and prevention of tuberculosis. Through HealthStream online format. 4.Director of Nursing, Infection Preventionist or Designee will audit completion of updated policy 1x/week for 3 weeks to ensure compliance with plan of correction of completion date 12/20/2023. Infection Preventionist or Designee will audit all new hires TB test results for 3 months. Findings will be brought to the following QAPI meeting to discuss and determine the need for further audits.	

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F 880	Continued From page 17 Review of January 2023, the facilities Tuberculosis (TB) risk assessment identified the facility had no resident suspected or confirmed with TB disease. The assessment identified the facility to be at a low risk for TB. The assessment identified the facility had no staff with a test conversion rate for TB infections that exceeded the health-care setting's annual average. There was no indication in the assessment that the facility identified they employed a staff with a positive TB test result. Review of 11/6/23, Tuberculosis-Employee Screening policy identified all staff will be screened for Tuberculosis (TB) infection and disease through a blood assay for Mycobacterium tuberculosis (BAMT) or two-step tuberculin skin test (TST) prior to working. If the results return as negative the staff will not be given another test prior to working. If the test results are positive or unavailable, the staff must have additional verification of absence of active TB. The policy furthermore identified staff who had a positive reaction to the TB test would be referred for a chest X-ray and symptom screening, which must be completed prior to working. If the staff chest X-ray results are negative and the staff has no symptoms of active TB, the staff will be considered free of active tuberculosis.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative	F 883		12/29/23

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	245231	A. BUILDING _____ B. WING _____	C 11/08/2023

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

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F 883	Continued From page 18 receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following:	F 883		

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F 883	Continued From page 19 (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R23) were appropriately vaccinated against pneumonia. Furthermore, the facility failed to have a method or system to ensure the facility offer or provided any initial or updated vaccine to residents per Centers for Disease Control (CDC) vaccination recommendations. Findings include: Review of the current CDC pneumococcal vaccine guidelines located at https://www.cdc.gov/vaccines/vpd/pneumo/hcp/pneumo-vaccine-timing.html, identified for: Adults 65 years of age or older, staff were to offer and/or provide based off previous vaccination status as shown below: a) If NO history of vaccination, offer and/or provide: aa) the PCV-20 OR bb) PCV-15 followed by PPSV-23 at least 1 year later. b) For PPSV-23 vaccine ONLY (at any age): aa) PCV-20 at least 1 year after prior PPSV-23 OR bb) PCV-15 at least 1 year after prior PPSV-23 c) For PCV-13 vaccine ONLY (at any age):	F 883	1. It is the policy of this facility to ensure all residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated, or the resident has already been vaccinated. Residents will be offered pneumococcal vaccines to prevent pneumococcal infections. Upon admission residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated will be offered the vaccine unless medically contraindicated. The pneumococcal vaccine or re-vaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations. The facility failed to ensure 1 of 5 residents (R23) were appropriately vaccinated against pneumonia. Furthermore, the facility failed to have a method or system to ensure the facility offer or provided any initial or updated vaccine to residents per Centers for Disease Control (CDC) vaccination recommendations. Review of the current CDC pneumococcal vaccine guidelines located at https://www.cdc.gov/vaccines/vpd/pneumo/hcp/pneumo-vaccine-timing.html,	

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F 883	Continued From page 20 aa) PCV-20 at least 1 year after prior PCV13 OR bb) PPSV-23 at least 1 year after prior PCV13 d) For PCV-13 vaccine (at any age) AND PPSV-23 BEFORE 65 years: aa) PCV-20 at least 5 years after last pneumococcal vaccine dose OR bb) PPSV-23 at least 5 years after last pneumococcal vaccine dose e) Received PCV-13 at any age AND PPSV-23 AFTER Age 65 Years: aa) Use shared clinical decision-making to decide whether to administer PCV20. If so, the dose of PCV-20 should be administered at least 5 years after the last pneumococcal vaccine. Review of 1 of 5 sampled residents for vaccinations identified: 1) R23 was over 65 and admitted to the facility September of 2019. R23 had the PCV-13 on 10/20/15 and PPSV-23 on 11/14/12. R23 should have been offered and /or administered the PCV-20 at least 5 years after prior PCV-13 in October of 2015. Interview on 11/7/23 at 2:44 p.m., with registered nurse (RN)-B identified the case manager was responsible to complete the TB screening and testing for new admissions. The case manager was responsible to review the new admission records and offer immunizations that were due or document on the immunization spreadsheet when an immunization would be next due. RN-B confirmed the facility followed CDC guidelines for recommended vaccinations. Interview on 11/7/23 at 3:48 p.m., with infection	F 883	identified for: Adults 65 years of age or older, staff were to offer and/or provide based off previous vaccination status as shown: Received PCV-13 at any age AND PPSV-23 AFTER Age 65 Years: aa) Use shared clinical decision-making to decide whether to administer PCV20. If so, the dose of PCV-20 should be administered at least 5 years after the last pneumococcal vaccine. 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 vaccination requirements under the direction of the Director of Nursing: a.MDS care coordinators will assess resident's immunization status upon admission, update the teams "resident immunization tracking excel sheet", arrange for immunizations if indicated, obtain consent for indicated vaccinations, provide education, and update medical record if indicated. Residents' immunization status will be reviewed to ensure immunizations are up to date per CDC vaccination requirements quarterly with MDS ARD's. b.Immunization/Vaccination Policy to be updated and reviewed at the next QAPI meeting in January. c.Infection Preventionist will monitor vaccination requirement updates, review CDC vaccination requirements annually, and update care center IDT of any	

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F 883	Continued From page 21 preventionist (IP) identified this was the first time he had heard about the PCV-15 and the PCV-20 vaccination. Interview on 11/8/23 at 1:17 p.m., with director of nursing (DON) identified R23 was not offered the new PCV-15 or PCV-20. The DON revealed that she was honestly unaware of the PCV-20 however when she reviewed the vaccine information statements (VIS) sheet there it was right next to the information on the PCV-15. She further reported that the nurse manager was responsible to track and offer immunizations that were due. Review of the 11/6/23, Pneumococcal policy identified residents will be offered pneumococcal vaccines to prevent pneumococcal infections. Upon admission residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated will be offered the vaccine unless medically contraindicated. The pneumococcal vaccine or re-vaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations.	F 883	changes and updates. 4.Director of Nursing or Designee will randomly audit residents' vaccination status 1x/month for 3 months, then discuss findings at QAPI to determine the need for further audits.	

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/6/23 through 11/8/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H52317022C (MN98261) and NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		

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2 000	Continued From page 2 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. http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of	21426		12/20/23

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21426	Continued From page 3 Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to act on a positive tuberculosis (TB) test result for 1 of 5 staff (housekeeping (HSK)-A) tested for active TB upon hire. Furthermore, the facility failed to ensure any person or persons with a positive history of TB was added to surveillance to mitigate potential risks for spread of possible active TB. This had the potential to affect all 43 residents, other staff, and visitors. Findings include: Review of housekeep (H)-A's employee file identified on 3/15/23, H-A's baseline TB Screening and questionnaire identified H-A had no symptoms of active TB however, it was identified that H-A had lived in Micronesia, and it was unknown if Micronesia had a high TB rate. Review of the National Library of Medicine (NIH) website, located at	21426	1. It is the policy if this facility that all employees shall be screened for tuberculosis (TB) infection and disease, using a two-step tuberculin skin test (TST) or blood assay for Mycobacterium tuberculosis (BAMT) and symptom screening, prior to beginning employment. If positive, will be referred for a chest x-ray and medical evaluation. The need for annual testing shall be determined by the annual TB risk classification or as per State regulations. The facility failed to act on a positive tuberculosis (TB) test result for 1 of 5 staff (housekeeping (HSK)-A) tested for active TB upon hire. Furthermore, the facility failed to ensure any person or persons with a positive history of TB was added to surveillance to mitigate potential risks for spread of possible active TB. This had the potential to affect all 43 residents, other staff, and	

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21426	Continued From page 4 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3000724, identified the Federated States of Micronesia is a US-affiliated jurisdiction that comprises more than 600 islands dotted across 1 million square miles in the western Pacific Ocean. Micronesia is a low-income country where 27% of the people live below the US poverty line. While TB incidence in the United States continues to drop (4.4 reported cases per 100 000 population in 2007), Micronesia has sustained some of the highest rates of TB among the US-affiliated Pacific Islands (169 reported cases per 100 000 in 2008). Further review of H-A's Baseline TB Screening Tool for Healthcare Workers, identified H-A's hire date was 3/27/23. The form identified questions related to symptoms of active TB which were to be circled if present. The answer was listed as "none". The screening form noted if TB symptoms were present staff would promptly be referred for a chest X-ray and medical evaluation prior to working. The screening form further had questions about staff's personal history such as if the employee had ever had a positive test result, which was answered "no" on H-A's form. There was also a question asking if the staff had been a temporary or permanent residence in a country with a high TB rate for a month or longer (any country other than the United States, Canada, Australia, New Zealand, and those in Northern Europe or Western Europe). The answer was "yes", with a note next to the answer "if Micronesia counts". All other questions on the screening form to determine if active TB or symptoms of TB were present were answered as "no". Review of H-A's QuantiFERON-TB Gold Result identified as abnormal. The QuantiFERON-TB	21426	visitors. Review of (HSK)-A's employee file identified on 3/15/23, (HSK)-A's baseline TB Screening and questionnaire identified (HSK)-A had no symptoms of active TB however, it was identified that (HSK)-A had lived in Micronesia, and it was unknown if Micronesia had a high TB rate. Review of the National Library of Medicine (NIH) website, located at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3000724 identified the Federated States of Micronesia is a US-affiliated jurisdiction that comprises more than 600 islands dotted across 1 million square miles in the western Pacific Ocean. Micronesia is a low-income country where 27% of the people live below the US poverty line. While TB incidence in the United States continues to drop (4.4 reported cases per 100 000 population in 2007), Micronesia has sustained some of the highest rates of TB among the US-affiliated Pacific Islands (169 reported cases per 100 000 in 2008). Review of March through November 2023, resident infection, and illness surveillance log had no evidence of residents with signs or symptoms of active TB and the staff infection and illness surveillance log had no evidence that HSK-A had ever called in to report any illness. The surveillance lacked identification of increased surveillance for HSK-A who had a known positive TB test result for signs or symptoms of active TB, that would have put all 43 residents at risk. 2. All residents have the potential to be affected by stated deficiency; no similar findings and/or negative effects have been	

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21426	Continued From page 5 Gold test was completed on 3/17/23, with the results verified on 3/19/23 as "positive". "Interferon-gamma response to M. tuberculosis antigens detected, suggesting infection with M. tuberculosis. Positive results in staff at low risk for tuberculosis should be interpreted with caution and repeat testing should be considered as recommended". There was no indication test results were repeated for accuracy. Review of March through November 2023, resident infection and illness surveillance log had no evidence of residents with signs or symptoms of active TB and the staff infection and illness surveillance log had no evidence that H-A had ever called in to report any illness. The surveillance lacked identification of increased surveillance for H-A who had a known positive TB test result for signs or symptoms of active TB, that would have put all 43 residents at risk. Interview on 11/7/23 at 3:48 p.m., with infection preventionist (IP) identified that he was not aware of H-A's positive TB test result until H-A's information was requested as part of the sample of staff to be reviewed for TB screening and testing. He reported "the minute" he reviewed the test results and saw H-A's positive result, he immediately sent H-A for a medical exam and chest X-ray. He was unsure why the previous IP had not acted upon the positive results. He confirmed he reviewed all the resident surveillance and found no residents to have had signs or symptoms of active TB since H-A started working. He further confirmed staff were not to start employment until a TB negative result was obtained per the facility policy and was the facility policy to not hire any staff with an active TB test. Review of H-A's 11/7/23, Chest X-ray result were	21426	identified by this alleged deficient practice. 3. To enhance currently compliant new hire screening requirements under the direction of the Director of Nursing: a.The Tuberculosis- Employee Screening Policy will be updated and reviewed at the January 2024 QAPI meeting for approval or changes needed. b.The Baseline TB Screening form has been updated so questions are easier to understand. c.Director of Ancillary Services/Current Infection Preventionist updated Quantiferon Laboratory result to be identified as a Critical Lab Result both Human Resources and Infection Preventionist will be notified via in person or by phone of critical result and the employee will not be able to start working until chest x-ray and medical evaluation to rule out active TB symptoms indicate safe to work. Policy to reflect this plan as well. d.TB education for Care Center Nursing Staff at December 2023 Nurse/CNA Meetings. e.All staff are required to complete annual education on Tuberculosis control, prevention, and treatment. The module reviews the causes of TB, risk factors, symptoms, transmission, and prevention of tuberculosis. Through HealthStream online format. 4. Director of Nursing, Infection Preventionist or Designee will audit completion of updated policy 1x/week for 3 weeks to ensure compliance with plan of correction of completion date 12/20/2023. Infection Preventionist or Designee will	

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21426	Continued From page 6 negative. There was no physician progress note to review related to the medical examination portion. Interview on 11/8/23 at 1:17 p.m., with director on nursing (DON) identified she was unaware H-A had a positive TB test result on 3/19/23. The DON reported the IP was responsible for ensuring new hires were screened and had laboratory testing for active TB and found positive, they were to be sent for a medical exam and/or chest X-ray with a physician. The IP was responsible to act on any positive TB results and file the results in the staff personnel file. The previous IP ended her employment on 8/1/23. H-A was employed full time and had never called in for work since starting her employment. Staff were not allowed to work at the facility if a staff was shown positive until they had a repeat test showing it was truly negative. Review of January 2023, the facilities Tuberculosis (TB) risk assessment identified the facility had no resident suspected or confirmed with TB disease. The assessment identified the facility to be at a low risk for TB. The assessment identified the facility had no staff with a test conversion rate for TB infections that exceeded the health-care setting's annual average. There was no indication in the assessment that the facility identified they employed a staff with a positive TB test result. Review of 11/6/23, Tuberculosis-Employee Screening policy identified all staff will be screened for Tuberculosis (TB) infection and disease through a blood assay for Mycobacterium tuberculosis (BAMT) or two-step tuberculin skin test (TST) prior to working. If the results return as negative the staff will not be given another test	21426	audit all new hires TB test results for 3 months. Findings will be brought to the following QAPI meeting to discuss and determine the need for further audits.	

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	00655	A. BUILDING: _____ B. WING _____	C 11/08/2023

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

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21426	Continued From page 7 prior to working. If the test results are positive or unavailable, the staff must have additional verification of absence of active TB. The policy furthermore identified staff who had a positive reaction to the TB test would be referred for a chest X-ray and symptom screening, which must be completed prior to working. If the staff chest X-ray results are negative and the staff has no symptoms of active TB, the staff will be considered free of active tuberculosis. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), IP, or designee should educate all appropriate staff on tuberculosis and tuberculosis screen policies and procedures. The DON, IP, or designee should develop monitoring systems to ensure ongoing compliance and include any residents or staff with a history of TB into their surveillance with enhanced measures to mitigate risks to residents, staff, and visitors. The facility should also have a plan to act upon any positive result. The results of that monitoring should go to the QAPI committee for continued oversight. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		

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	245231	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/07/2023**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/7/2023. 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.	K 000		

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

Electronically Signed | 12/02/2023

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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	245231	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/07/2023**

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APPLETON AREA HEALTH	**30 S BEHL ST** **APPLETON, MN 56208**

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K 000	Continued From page 1 Healthcare Fire Inspections 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 Municipal Nursing Home is a 2-story building with a no basement. The building was constructed at 3 different times. The original building was constructed in 1964 and was determined to be of Type II(000) construction. In 1976, an addition was added to the east that was determined to be of Type II(222). In 1992 an addition was added to the southeast that was determined to be of Type II(000) construction. Because the original building and the additions meet the construction type allowed for a Type II	K 000		

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K 000	Continued From page 2 (000) existing building, the facility was surveyed as one building. The building is fully sprinklered throughout. the facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 47 beds and had a census of 43 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353		11/8/23

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K 353	Continued From page 3 by: Based on observation and staff interview, the facility failed to inspect storage in sprinkler areas per NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.7, 9.7.8, and NFPA 25. This deficient findings could have a isolated impact on the residents within the facility. Findings include: On 11/7/2023 at 11:00AM, it was revealed by observation that in the lower activities storage room there were items stacked or stored vertically closer than 18 inches to the fire sprinkler head(s). An interview with the Administrator verified this deficient finding at the time of discovery.	K 353	K353 EVS/Safety Manager, Butch Olson removed all swept items from top shelf in basement storage room and emailed all users that nothing is to be stored on the top shelf. To ensure compliance with deficiency tag EVS/Safety Manager, LNHA or designee will audit basement storage room 2x/month for 3 months. 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.	
K 712 SS=D	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 the required quarterly fire drills per NFPA 101 (2012 edition), Life Safety Code, sections	K 712	EVS/Safety Manager, Butch Olson, or designee will be responsible for conducting required fire drills every shift, every quarter for the facility. EVS	11/8/23

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K 712	Continued From page 4 19.7.1.4 through 19.7.1.7. This deficient findings could have a isolated impact on the residents within the facility. Findings include: On 11/7/2023 at 11:00 AM, it was revealed by a review of available documentation that there is no fire drill report to review for the 2nd Shift in the 4th Quarter. An interview with the Adminstrator verified this deficient finding at the time of discovery.	K 712	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. No fire drill report to review for the second shift in the 4th quarter could be reviewed as the 4th quarter was 2022, during January 2023 annual survey this facility received the same tag for no fire drill report to review for the second shift in the 4th quarter. All required fire drills have been completed and documented since the January 2023 annual survey.	

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Electronically Signed | 12/02/2023

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