DEPARTMENT OF HEALTH

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

Electronically delivered
January 3, 2021

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

RE: CCN: 245231
Cycle Start Date: November 12, 2020

Dear Administrator:

On November 30, 2020, we notified you a remedy was imposed. On December 23, 2020 the Minnesota Department(s) of Health 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 December 18, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 14, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 30, 2020, 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 January 14, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 18, 2020, 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 Therefore, the NATCEP prohibition is rescinded.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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically delivered
November 30, 2020

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

RE: CCN: 245231
Cycle Start Date: November 12, 2020

Dear Administrator:

On November 12, 2020, a survey was completed at your facility by the Minnesota Department(s) of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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 January 14, 2021.

- 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 January 14, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 14, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

## NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by January 14, 2021, 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 January 14, 2021. 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" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Sarah Grebenc, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792

## 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 12, 2021 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:

Tamika.Brown@cms.hhs.gov

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

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

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

## 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.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

**DIRECTED PLAN OF CORRECTION**

**A Directed Plan of Correction (DPOC) is imposed in accordance with 42 CFR § 488.424. Your facility must include the following in their POC for the deficient practice cited at**

PERSONAL PROTECTIVE EQUIPMENT (PPE)

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

POLICIES/PROCEDURES/SYSTEM CHANGES:

- The facility's Quality Assurance and Performance Improvement Committee must conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence.

The Infection Preventionist and Director of Nursing, shall complete the following:

- Review policies and procedures for donning/doffing PPE during COVID-19 with current guidelines to include crisis standard of care, contingency standard of care and standard care.
- Develop and implement a policy and procedure for source control masks.
- Review policies regarding standard and transmission based precautions and revise as needed.

TRAINING/EDUCATION:

As a part of corrective action plan, the facility must provide training for the Infection Preventionist, the Director of Nursing, all staff providing direct care to residents, and all staff entering resident's rooms, whether it be for residents' dietary needs or cleaning and maintenance services. The training must cover standard infection control practices, including but not limited to, transmission-based precautions, appropriate PPE use, and donning and doffing of PPE.

- The training may be provided by the Director of Nursing, Infection Preventionist, or Medical Director with an attestation statement of completion.
- The training must include competency testing of staff and this must be documented.
- Residents and their representatives should receive education on the facility's Infection Prevention Control Program as it related to them and to the degree possible/consistent with resident's capacity.
- Online infection prevention training courses may be utilized. The CDC and MDH websites have several infection control training modules and materials.

CDC RESOURCES:

Infection Control Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html
CDC: Isolation Precautions Guideline:

https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007): https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
CDC: Personal Protective Equipment: https://www.cdc.gov/niosh/ppe/
Healthcare Infection Prevention and Control FAQs for COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control-faq.html

MDH RESOURCES:
Personal Protective Equipment (PPE) for Infection Control: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/ppe/index.html
MDH Contingency Standards of Care for COVID-19: Personal Protective Equipment for Congregate Care Settings (PDF): https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf
Interim Guidance on Facemasks as a Source Control Measure (PDF): https://www.health.state.mn.us/diseases/coronavirus/hcp/maskssource.pdf
Interim Guidance on Alternative Facemasks (PDF): https://www.health.state.mn.us/diseases/coronavirus/hcp/masksalt.pdf
Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF): https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf
Droplet Precautions: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html
Airborne Precautions: https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/droplet.html

MONITORING/AUDITING:

- The Director of Nursing, the Infection Preventionist, and other facility leadership will conduct audits of donning/doffing PPE with Transmission Based Precautions i.e. Droplet precautions.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct routine audits on all shifts four times a week for one week, then twice weekly for one week once compliance is met. Audits should continue until 100% compliance is met on source control masking for staff, visitors and residents.
- The Director of Nursing, Infection Preventionist, and other facility leadership will conduct real time audits on all aerosolized generating procedures to ensure PPE is in us.
- The Director of Nursing, Infection Preventionist, or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.

**In accordance with 42 CFR § 488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed on or after that date. The effective date is not a deadline for completion of the DPOC. However, a revisit will not be approved prior to receipt of documentation confirming the DPOC was completed. To demonstrate that the facility successfully completed the DPOC, the facility must provide all of the following documentation. Documentation should be uploaded as attachments through ePOC.**

**Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.**

| Item | Checklist: Documents Required for Successful Completion of the Directed Plan |
|---|---|
| 1 | Documentation of the RCA and intervention or corrective action plan based on the results with signatures of the QAPI Committee members. |
| 2 | Documentation that the interventions or corrective action plan that resulted from the RCA was fully implemented |
| 3 | Content of the training provided to staff, including a syllabus, outline, or agenda, as well as any other materials used or provided to staff for the training |
| 4 | Names and positions of all staff that attended and took the trainings |
| 5 | Staff training sign-in sheets |
| 6 | Summary of staff training post-test results, to include facility actions in response to any failed post-tests |
| 7 | Documentation of efforts to monitor and track progress of the interventions or corrective action plan |

**In order to speed up our review, identify all submitted documents with the number in the "Item" column.**

**Attach all items into ePOC.**

| 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 _____ | 11/12/2020 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>A COVID-19 Focused Infection Control survey was conducted 11/10/20, to 11/12/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations § 483.73(b)(6). The facility was in full compliance.<br><br>Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form.<br><br>Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A COVID-19 Focused Infection Control survey was conducted 11/10/20 to 11/12/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was not in compliance.<br><br>Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 880 SS=F | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f) | F 880 | | 12/18/20 |

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

Electronically Signed | 12/09/2020

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 245231 | A. BUILDING _____ B. WING _____ | 11/12/2020 |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 245231 | A. BUILDING _____ B. WING _____ | 11/12/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 |
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| F 880 | Continued From page 2<br>depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to follow the recommendations from the Centers for Disease Control (CDC) to prevent the spread of COVID-19 in long term care facilities which included wearing the appropriate personal protective equipment (PPE) for 1 of 1 (R1) residents who was on a 14 day quarantine due to potential exposure to COVID-19. Additionally, the facility staff were not aware of the dry time of the disinfectant wipes used to ensure effective sanitization of the reusable gowns. The facility practices had the | F 880 | 1)Starting on 11/11/2020 reusable gowns were no longer being used in the AAH Care Center. The use of single use gowns was implemented for all residents under observation or isolation and a new policy titled “Contingency and Crisis Capacity use of reusable gowns” was created to ensure proper use of reusable gowns if reusable gowns are implemented at any point in the future.<br><br>2)For all residents requiring isolation or | |

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| | 245231 | A. BUILDING _____ B. WING _____ | 11/12/2020 |

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

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| F 880 | Continued From page 3<br>potential to affect all 43 residents who currently reside in the facility as well as staff and visitors.<br><br>Findings include:<br><br>R1's interim care plan initiated on 10/27/20, identified R1 was admitted to the facility on 10/27/20, with the diagnosis of below the knee amputation of his left leg. R1's care plan indicated he transferred with assistance of one staff and was independent with many activities of daily living (ADL'S). The care plan indicated R1 was in quarantine for potential COVID-19 exposure until 11/10/20.<br><br>On 11/10/20, at 10:33 a.m. during observation and interview with licensed practical nurse (LPN)-A, a three drawer wooden bin was outside R1's doorway with a sign titled Doffing: Reusable Gowns on top of the bin. Another sign identifying Droplet Precautions was also on top of the bin. R1's door was halfway open and R1 was seated on the edge of the bed. Inside R1's doorway, two yellow reusable gowns hung on the wall on two different white hooks. LPN-A verified R1 was in 14 day quarantine due to being a new admission and stated the facility used reusable gowns for residents who were in 14 day quarantine. LPN-A stated all staff used the same gowns and sanitized them in between use with a purple disinfectant wipe and then hung them back on the hooks with the exposed side facing the wall. LPN-A stated she was not aware of the dry time for the purple disinfectant wipes and would have to look it up.<br><br>On 11/10/20, at 11:14 a.m. nursing assistant (NA)-A stated staff used the same reusable gowns for residents who were in 14 day | F 880 | observation precautions, single use gowns have been used to ensure no other residents or staff had the potential to be affected by the deficient practice.<br><br>3)On 12/8/2020 QAPI Committee completed a root cause analysis to identify why the problem occurred and how to correct the practice. The best strategy to stop the deficient practice was to switch to using single use gowns until single use gowns are at contingency or crisis capacity in our facility. At that point we will switch to our “contingency and crisis capacity use of reusable gowns” to continue to protect staff and other residents from becoming infected. The QAPI committee has approved the new policy and will complete audits of the process to ensure single use gowns are being used until contingency or crisis level is reached.<br><br>4)DON will educate staff on 12/11/2020 at AAH covid testing event by creating education packets relating to reusable gowns, when to use them, and proper use of the reusable gowns. DON will be present to go through the packet and answer questions any staff member may have. All staff who may enter a resident’s room will complete the training. The packet will also include information on all cleaning products to indicate their dwell times. The dwell time posters are also hung around the facility to provide easy access of the information for staff who are cleaning or disinfecting different areas. Competencies will be attached regarding | |

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|---|---|---|---|
| | 245231 | A. BUILDING _____ B. WING _____ | 11/12/2020 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 880 | Continued From page 4<br>quarantine and explained the facility used a buddy system for donning and doffing the gowns. NA-A stated the staff member who wore the gown, donned the gown while another staff member stood behind and fastened the back strap. NA-A explained when it was time to remove the gown, the staff member who wore the gown wiped off the front of the gown and another staff member wiped off the back of the gown with the purple disinfectant wipes. NA-A stated the staff member who wore the gown then removed the gown and hung it on the hook on the wall by the doorway being careful to place the side exposed to the resident against the wall. NA-A stated the dry time for the purple disinfectant wipe was 10 seconds.<br><br>On 11/10/20, at 12:10 p.m. NA-B stated staff shared the same reusable gowns for residents who were on 14 day quarantine. NA-B stated the facility used a buddy system to assist with donning and doffing the gown where the employee who wore the gown wiped the front of the gown off with a purple disinfectant wipe after use and another staff member stood behind wiped down the back of the gown with a purple disinfectant wipe and hung the gown on the hook on the wall by the doorway. NA-B stated she did not know the dry time for the purple disinfectant wipes.<br><br>On 11/10/20, at 12:20 p.m. director of nursing (DON) indicated he shared the role of infection preventionist with the Laboratory Director. DON stated the facility considered residents who were on 14 day quarantine as potentially infected with COVID-19. DON stated the facility used reusable wipe-able gowns for residents in 14 day quarantine and confirmed staff shared the gowns. | F 880 | the use of reusable gowns as well as dwell times and where to find the information quickly if staff are unsure.<br><br>5)DON Will complete CMS QSEP training on Covid-19 infection control by 12/18/2020.<br><br>6)DON, ADON, IP will complete audits relating to gown use for residents under observation or covid-19 positive. Audits will be completed to ensure proper type of gown is used as well as proper application of the gown. Audits will occur 4x weekly for 1 month, then 2 x weekly for the following month, then continue until 100% compliance is met and sustained with 10 different fully compliant observations. Audits will be completed on both day and night shifts.<br><br>7)DON, ADON, IP, and environmental service manager will audit use of cleaning products by staff, specifically identifying proper dwell time usage. Staff will be audited to ensure they are using the product safely and effectively.<br><br>8)All completed audits will be reported to the QAPI committee to determine if further action should occur.<br><br>9)Completion of this plan of correction will ensure no residents can be effected by use of reusable gowns or by insufficient use of cleaning products relating to dwell times. | |

| 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 _____ | 11/12/2020 |

| 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 880 | Continued From page 5 | F 880 | | |

DON stated the facility practiced a buddy system for sanitizing the gowns where the staff person wearing the gown wiped the front of the gown with a disinfectant wipe and another staff person standing behind wiped down the back of the gown with a disinfectant wipe. The staff were expected to hang the reusable gown on the hook on the wall with the exposure side facing the wall. DON stated R1's last day of the 14 day quarantine was 11/9/20, and indicated staff had removed the gowns, PPE bins and signs after the observation completed earlier at 10:33 a.m. DON confirmed the facility used the purple Super Sani-Cloth Germicidal Wipes and indicated they had a dry time of 2-10 minutes.

Review of the sign present on the PPE bin for R1 titled Doffing: Reusable Gowns instructed staff to remove gloves, perform hand hygiene, reapply gloves, use disinfectant wipes to wipe the front of gowns that were exposed to patient, remove gloves, perform hand hygiene, have PPE buddy untie the back of the gown and carefully remove gown and hang with outside of gown facing away from and perform hand hygiene with soap and water.

Review of facility policy titled COVID-19 Use of Personal Protective Equipment When Caring for Individuals with Confirmed or Suspected Case of COVID-19 revised 5/2020, instructed staff to use disinfectant wipes to wipe the front of gowns that were exposed to patient. Additionally, the policy instructed staff to have PPE buddy untie the back of the gown, carefully remove the gown and hang with outside of the gown facing towards the wall.

Review of manufacturer's guidelines for Super Sani-Cloth Germicidal Wipes revised 3/13/20,

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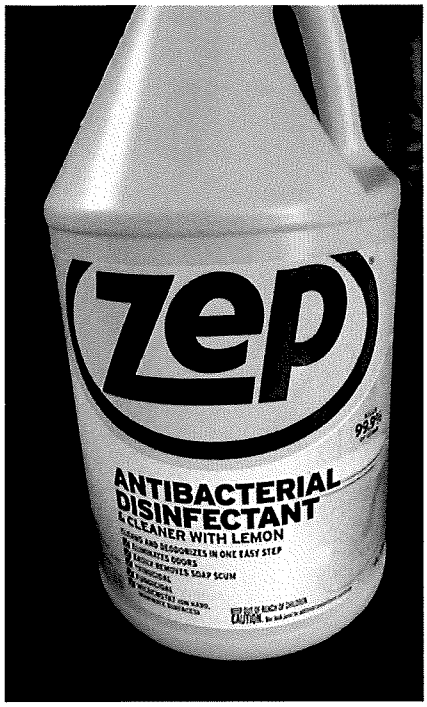
|---|---|---|---|---|
| F 880 | Continued From page 6<br>identified the wipes contact dry time was two minutes to be effective in killing the COVID-19 virus. | F 880 | | |

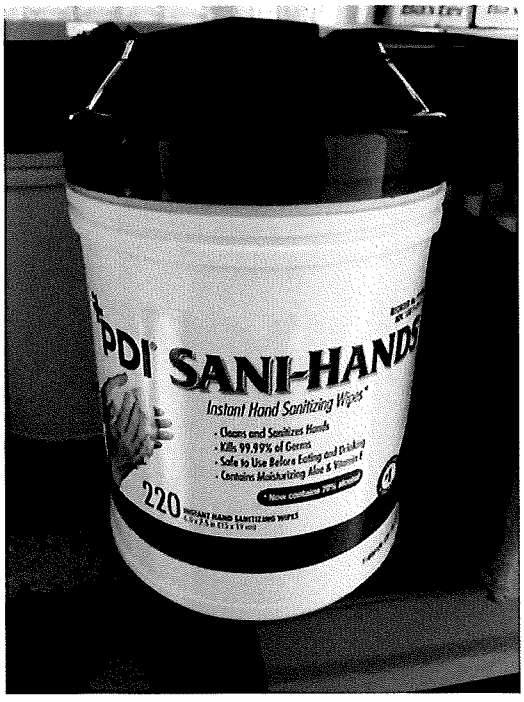
# COVID-19 Product Dwell Time




1 minute


1 minute


2 minutes




2 minutes

- Any gown that becomes soiled during patient care should be laundered.
- Utilize antiviral cleaners (such as Sani-cloths or QTTB) to clean gowns inbetween each use.
- All gowns will be laundered inbetween each shift.
- Reusable gowns should not be shared between staff. If multiple staff are working with the same resident, each staff should have their own individual gown that can be reused by that same staff only.
- When finished, the gown should be hung up and labeled with the staff members name to ensure no other staff use the same gown.

Once PPE supplies and availability return to normal, healthcare facilities should promptly resume conventional practices.

Refrence: Centers for Disease Control and Prevention, "Gowns" https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html#contingency-capacity

## Attachments

No Attachments

## Approval Signatures

| Approver | Date |
|---|---|
| Beth Taylor: ADON | pending |
| Mitch Ejnik | 12/2020 |