



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 12, 2025

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

RE: CCN: 245231
Cycle Start Date: January 29, 2025

Dear Administrator:

On January 29, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that 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.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Nicole Dahl, RN, Regional Operations Supervisor

Marshall District Office

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 29, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 29, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

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<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245231	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER APPLETON AREA HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 30 S BEHL ST APPLETON, MN 56208		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments On 1/27/25 through 1/29/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities 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 1/27/25 through 1/29/25 a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. 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 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758			1/29/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/20/2025

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 758	Continued From page 1 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their	F 758			

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F 758	Continued From page 2 rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R32) was reassessed for as needed (PRN) anti-anxiety medication (diazepam) every 14 days to ensure the appropriateness of continued use. Findings include: R32's 10/8/24, Significant Change Minimum Data Set (MDS) identified R32 had a diagnoses of Alzheimer's and dementia with agitation. R32 was cognitively impaired and was administered antipsychotic, antianxiety and antidepressant medication daily. R32's diazepam was ordered on 11/8/24 and started the same day, however, there was no indication the physician (MD) had limited the order for 14 days to ensure it was reviewed for continuation. R32's December 2024, Medication Administration Record (MAR) identified diazepam 5 milligram (mg) was to be given by mouth every 8 hours as needed for agitation, physical aggression, and restlessness beginning 11/08/24. The MAR lacked documentation of an end date. R32's Progress note identified on:			F 758	1.It is the policy of this facility that all residents will be free from unnecessary use of psychotropic medications and PRN use. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: Anti-psychotic, Anti-depressant, Anti-anxiety, and Hypnotic. Psychotropic drug use in long-term care (LTC) settings is carefully regulated due to the potential risks of side effects, overuse, and misuse, especially in vulnerable populations such as elderly individuals with dementia or other cognitive impairments. Any psychotropic medication that is prescribed on an as needed basis will be seen by a provider for face to face visit every 14 days and discontinued when deemed unnecessary. The facility failed to ensure 1 of 5 residents (R32) were reassessed for as needed (PRN) anti-anxiety medication (diazepam) every 14 days to ensure the appropriateness of continued use. 2.All current residents have potential to be affected by stated deficiency; no similar findings and/or negative effects have		

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F 758	Continued From page 3 1) 11/26/24, the physician ordered PRN diazepam and was to be reviewed in 14 days. 2) 11/26/24, the pharmacist's (RPh) recommendation identified staff were to monitor R32's behaviors. The pharmacist identified the physician (MD) reviewed the diazepam and the order was extended to 14 days. 3) 12/10/24, the nurse practitioner (NP) reviewed R32's diazepam. R32's behaviors had improved with medication management and the NP extended the diazepam 14 days. 4) 12/28/24, the RPh recommendation identified R32's diazepam was reviewed. They had no recommendations. There was no mention the RPh had identified the MD reviewed the diazepam within 14 days by 12/24/24. R32's December 2024, Treatment Administration Record (TAR) identified a reminder for staff to notify the MD to review the diazepam prior to the end of the 14 days to justify the continuation of the need for the medication. Review of the printed December 2024, TAR given to the MD on 1/15/25 identified staff wrote FYI: Nursing orders require notification of use of R32's diazepam in the last 14 days. There was no indication staff had notified the MD prior to 1/15/25 to review the diazepam and justify the continued use and place a new order. R32's current, undated care plan identified R32 had taken diazepam for anxiety. Staff were to administer anti-anxiety medications and monitor for the effectiveness of the medication and report adverse reactions and side effects such as memory loss, slurred speech, confusion, or nausea. Staff were to monitor and record target behaviors and inappropriate responses to verbal communication and violence and/or aggression			F 758	been identified by this alleged deficient practice. 3.To enhance the Care Center psychotropic medications usage, under the direction of the Director of Nursing, and the interdisciplinary team have collaboratively identified the RCA of the cited deficiency. In addition to the following: a.Care Coordinator immediately obtained orders to discontinue PRN diazepam as it wasn't used in a long time. b.A nursing order will be placed in the TAR to refer PRN diazepam use to on-call provider Q 14 days to re-evaluate further indication or discontinuation. Obtain orders to continue or D/C, document in progress notes. i.The original nursing order in the TAR didn't instruct the nurses to obtain orders to continue or D/C. They sent a note on the providers' clipboard, however, that provider was out of the facility for 2 weeks and there was no follow through. c.The policy for psychotropic medication usage will be updated with clear expectations of order follow through and nurses will read and sign off on the understanding of the updated		

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F 758	Continued From page 4 towards staff or others. There was no mention staff were to notify the MD to review the diazepam at 14 days to continue the medication. During interview and TAR review on 1/29/25 at 10:09 a.m., with licensed nurse (LPN)-A identified R32's TAR provided reminders for the nursing staff to notify the MD to review the diazepam every 14 days. LPN-A agreed there was documentation to support the provider was contacted on 12/24/24. Interview on 1/29/25 at 10:10 a.m., with LPN-B identified she agreed R32's PRN order should have been reviewed by the provider every 14 days. Interview on 1/29/25 at 11:41 a.m., with medical director identified staff should have notified the MD for R32 by day 14 to have the MD review the diazepam and document the rational to continue the order. Interview on 1/29/25 1:29 p.m., with director of nursing (DON) identified her expectation was for to staff notify the MD of the absence of a stop date on limited 14-day psychotropic medications and notify the MD if re-evaluation of the medication needed to occur for continuation. Review of October 2019, Psychotropic Medication Usage policy indicated the facility was to monitor residents receiving psychotropic medications to evaluate their effectiveness. In addition, the facility was to ensure a process for reviewing the continued need for psychotropic medications. There was no mention how the facility ensure duration of psychotropic medication use was enforced.	F 758	policy by 3/28/2025. d.Charge nurse and/or Care Coordinator will notify DON/ADON of all newly prescribed anti-psychotropics. 4.Director of Nursing, Assistant Director of Nursing or designee will audit PRN psychotropic medication use 2x/month x 2 months for 100% compliance of appropriateness of that medication. Audit results will be brought to the QAPI committee for review and action, as appropriate. The QAPI committee will determine the need for further audits and/or action plan.		

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

PRINTED: 02/27/2025
FORM APPROVED
OMB NO. 0938-0391

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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 §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to:	F 880			3/28/25

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F 880	Continued From page 6 (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 have a current, ongoing system of surveillance to identify potential outbreaks of infectious disease, ensure transmission-based precautions (TBP) were implemented timely, perform root cause analysis with contact tracking to identify patterns of illness in staff or residents, and prohibit staff from returning to work prematurely following identified symptoms. This had the potential to affect all 33 residents in the facility. In addition, the facility failed to ensure 1 of	F 880	1.It is the policy of this facility to abide by state and federal regulations related to maintaining an infection prevention and control program designed for a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The policy labeled Bath-Shower/Tub states, clean the bathtub with a disinfectant solution per manufacturers guidelines as attached. Per manufacturers		

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F 880	Continued From page 7 1 whirlpool tub was appropriately disinfected between resident use according to the manufacturer's directions. This had the potential to affect 10 of 32 residents who used the whirlpool tub. Findings include: SURVEILLANCE RESIDENTS Review of the December 2024, resident infection control log identified the facility experienced a COVID-19 outbreak between (December 15, 2024, through January 20, 2025). 17 of 32 residents were identified as testing positive for COVID-19 between December 15, through 31, 2024, (R1, R2, R7, R10, R13, R14, R15, R18, R19, R23, R24, R25, R32, R33, R86, R87, and R88). Review of the January 2025, infection control surveillance log identified one resident tested positive (R27). The resident surveillance logs above identified the resident name, room number, date tested positive, and off isolation date. The log failed to identify the date and type of TBP and when the precautions were implemented. STAFF Review of the staff infection control log for November 2024 identified call-ins for illness as follows: 1)Registered nurse (RN)-A reported vomiting on 11/11/24 with no additional follow up or notation of when she returned to work. She then also reported headache, fever, cough, sore throat and	F 880	guidelines the disinfectant should sit for 10 mins before rinsing. The facility failed to ensure 1 of 1 whirlpool tub was appropriately disinfected between resident use according to the manufacturer s directions. No residents were negatively affected by the cited deficiency. 2.All residents have the potential to be affected by the cited deficiency related to the deficient practice during the process of disinfecting the whirlpool tub in the care center. 3.To enhance the Care Center infection control program and under the direction of the Director of Nursing, and the interdisciplinary team have collaboratively identified the RCA of the cited deficiency. In addition to the following: a. The cleaning instructions were immediately hung in the tub room to replace the missing instructions. b. The policy labeled Bath- Shower/Tub will be revised to provide a clear expectation of the cleaning/disinfecting of the whirlpool tub by 3/28/2025. c. Staff will be informed of the updated policy and sign off on understanding of the revised policy by 3/28/2025 d. The Assistant Director of Nursing or designee will do competencies on the cleaning/disinfecting process of the		

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F 880	Continued From page 8 body aches on 11/24/24 and tested positive for COVID. 2) Nursing assistant (NA)-A reported vomiting, nausea, cough on 11/11/24. 3) Unidentified staff person-reported illness on 11/12/24 with no S/S identified. 4) Licensed practical nurse (LPN)-C -reported a sore throat on 11/18/24 with no additional S/S identified. 5) NA-B- reported illness with vomiting on 11/20/24. 6) NA-C- reported illness with vomiting, diarrhea, nausea, and cough on 11/21/24. 7) NA-D reported illness with vomiting on 11/21/24. 8) LPN-D- reported illness with vomiting and diarrhea on 11/25/24. 9) NA-E-reported illness with diarrhea on 11/25/24. 11) NA-F-reported illness with diarrhea on 11/26/24 There was no mention of any additional follow up, potential testing or identification of when staff were cleared to be able to return to work. Review of the staff infection control log for December 2024 identified 1 staff illness. NA-F-reported ill with no S/S identified and was tested positive for COVID-19. There was no mention of any additional follow up, potential testing or identification of when staff were cleared to be able to return to work. Review of the staff infection control log for January 2025 identified 3 staff illness: 1) An unidentified staff reported illness of vomiting, nausea, and headache on 1/4/25. 2) NA-E reported illness of "flu symptoms" on 1/9/25.	F 880	whirlpool with CNAs to ensure staff are competent by 3/28/2025. e. All newly hired CNAs will be educated on the cleaning/disinfecting process and will complete competencies. f. Records of competencies will be kept in DON office in POC 2025 binder and copies will be placed in staff charts. 4. Director of Nursing, Assistant Director of Nursing or designee will audit proper cleaning of the whirlpool tub throughout their shift 3x/week x 2 weeks, 2x/week x 2 weeks, 1x/week x 2 weeks. Audit results will be brought to the QAPI committee for review and action, as appropriate. The QAPI committee will determine the need for further audits and/or action plan. 1. It is the policy of this facility to abide by state and federal regulations related to maintaining an infection prevention and control program designed for a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The policy labeled Infection Control Plan states, an employee illness log is located on public share drive. Each department head is responsible for entering employees information regarding using sick time. At Infection Control Meetings this log will be reviewed for trends within employee health. The		

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F 880	Continued From page 9 3) RN-A reported illness of vomiting and fever on 1/13/25. There was no mention of any additional follow up, potential testing or identification of when staff were cleared to be able to return to work. Interview on 1/27/25 at 5:00 p.m., with the director of nursing (DON) identified there was no documentation of the type or when TBP had been initiated on the surveillance logs. She also observed the staff illness tracking and confirmed the documentation was incomplete and should have listed staff S/S, time off work, date of return, and if they had been seen by a medical provider or had any testing for illness completed. When a staff call in was reported either she or the scheduling coordinator were to attempt to contact the employee to discover the reason for call in if it was not documented. Interview on 1/27/25 at 6:27 p.m., with LPN-E identified LPN-E worked as the charge nurse and if a staff person called in for themselves of a child, she would use the provided illness form, document the name of the staff person, S/S if they were provided and if they reported plan to see a medical provider. If they were calling in for a child, she might ask for the S/S, but reported she was not certain if she had done so. She stated the ill slip was then given to the scheduler, but she was not certain what happened after that. Interview on 1/27/25 at 6:34 p.m., with RN-B identified when a staff member called as ill, she recorded the information in the binder located at the nursing station and had spaces to record S/S, time of the call, and if the staff member was seeing a provider. She reported she recorded the information that was given, but the person calling	F 880	facility failed to have a current, ongoing system of surveillance to identify potential outbreaks of infectious disease, ensure transmission-based precautions (TBP) were implemented timely, perform root cause analysis with contact tracking to identify patterns of illness in staff or residents and prohibit staff from returning to work prematurely following identified symptoms. No residents were negatively affected by the cited deficiency. 2.All residents have the potential to be affected by the cited deficiency related to the deficient practice of tracing and identifying patterns of illness in staff or residents and prohibiting staff from returning to work prematurely following identified symptoms. 3.To enhance the Care Center infection control program and under the direction of the Director of Nursing, and the interdisciplinary team have collaboratively identified the RCA of the cited deficiency. In addition to the following: a. A new employee illness log was located by ICAR and immediately implemented. b. A new policy will be created for employee illness reporting by 3/28/2025. c. Staff will be informed of the updated policy and sign off on the understanding of the revised policy by 3/28/2025.		

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F 880	Continued From page 10 in, did not always give the information. She stated the form was routed to infection control, but she was not aware of any follow up process. Interview on 1/29/25 at 9:08 a.m. with the infection preventionist (IP) identified she agreed employee tracking was incomplete and noted she failed to include determination of S/S, if the employee was seeing a medical provider and when it was appropriate for them to return to duty. She did receive calls from staff at times about a family member's illness, but did not perform tracking or trending or follow up about potential precautions due to contact. Interview on 1/29/25 at 11:13 a.m., with the scheduling coordinator confirmed she was only aware of one call in for a staff member in December who tested positive for COVID and three call ins for January 2025 one with "flu symptoms" and two with no S/S identified. She confirmed when a staff called in ill, they were supposed to give the reason for their absence, if they were seeking medical attention, and S/S of either their or family member's illness but confirmed this did not consistently occur. Following receipt of the paper slip, her job was to enter the information into the electronic employee illness log but was not aware of who/what/when reviewed further. WHIRLPOOL Interview on 1/28/25 at 10:15 a.m. with the environmental services (EVS) manager identified the whirlpool tub as a jetted Penner tub with water jets. The disinfectant used as CenKleen IV-Quaternary Ammonium compound disinfectant mixed at ratio of 1 ounce/gallon and filled by EVS	F 880	d. The scheduling coordinator will be responsible for monitoring call ins and updating the employee illness log. e. The scheduling coordinator will be responsible for informing IP, DON, and ADON of illnesses and informing staff of their return time per the direction of IP/DON. f. The employee illness log will be in Teams and the DON, ADON, IP and Scheduling Coordinator will have access to the log. 4. Director of Nursing, Assistant Director of Nursing or designee will audit the employee illness log to ensure completion and identify any concerns 5x/week x 2 weeks, 3x/week x 2 weeks, 1x/week x 2 weeks. Audit results will be brought to the QAPI committee for review and action, as appropriate. The QAPI committee will determine the need for further audits and/or action plan.		

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F 880	Continued From page 11 staff for nursing staff to be used for cleaning and disinfecting the tub. Observation and interview on 1/29/25 at 3:30 p.m. with NA-G as she cleaned and disinfected the Penner Spa tub identified NA-G returned the bath chair to the tub and secured the door. She retrieved the quart spray bottle of Cev-Kleen IV cleaner, applied gloves placed the plug in the bottom of the tub, and using the spray bottle sprayed all surfaces of tub and chair by with the spray bottle. She then ran water into tub to above the level of the jets. While the tub was filling with water, she used a long-handled brush to bush the surfaces of the tub and chair by dipping the brush into the water and then onto the sprayed surface of the tub and chair. NA-G pushed the button labeled jet rinse and stated she held it for a few seconds. NA-G reported she allowed the solution to sit for 1-3 minutes to allow it to disinfect the surfaces and used the hand sprayer to spray off all surfaces. No clock or timer was observed in the tub room. As she waiting the solution on the sides of the tub and chair were observed to be drying. When asked how long she needed to wait, since there was no clock in the room, NA-G replied she had looked at her watch and timed it for 2 minutes. She then took the hand sprayer and rinsed off the tub sides and chair, and allowed the solution to drain from the tub and rinsed all surfaces again. NA-G released the latch on the back of the tub and reported she left the seal open, so it was able to dry. She was not aware of an instruction sheet being posted in the tub room and identified that was how she had been trained to clean and disinfect the whirlpool tub and was unaware of manufacturer's instructions requiring a specif amunt of disinfectant to be infused into the water in the	F 880			

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F 880	Continued From page 12 base of the well and run for 10 min, keeping surfaces wet was required for appropriate disinfection. Review of the Penner Spa Tub manufacture's guide for cleaning and disinfection of the tub following resident bath listed: 1) The tub was to be rinsed initially rinsing all surfaces with the shower sprayer, 2) Drain any water, and then refill by pressing the disinfect button which allows the properly mixed cleaning solution to run through the system. 3) Release the button after you see solution coming out of the jets and have 1 1/2 gallons of disinfectant solution in the foot well of the tub. 4) Scrub all surfaces of the tub and chair with the solution that remains in the well of the tub 5) Let disinfectant remain on the surface for 10 minutes or as recommended on the disinfectant container. 6) Remove the plug from the drain. 7) Rinse the soapy water away. 9) Press and hold the rinse button until water runs clear. . Interview on 1/27/25 at 5:00 p.m., with the director of nursing (DON) identified she was not aware there was no longer a sign with cleansing/disinfecting instructions posted in the tub room. She stated her expectation for the tub to be cleansed and disinfected according to the manufacturer's instructions. Both the ADON and DON reported they would take immediate action to correct the procedure. Later interview on 1/29/25 at 11:20 a.m., with the DON identified she had reviewed the manufacture's guidelines for the whirlpool tub and confirmed staff were not following the			F 880			

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F 880	Continued From page 13 manufacture's guidelines. Review of the 3/15/24, infection control plan identified the IP and committee were to develop evidence-based national guidelines in the development of the infection prevention and control program. The employee illness log was identified as available on the facility's shared drive with each department head responsible to log sick time utilized by their employees. The nursing home was identified as responsible for sending their data to the IP monthly with the information to be reviewed at the infection control meetings. The Center for Disease Control (CDC) National Healthcare Safety Network (NHSN) surveillance methodology was to be utilized by the facility. The IP was to coordinate and review infection control issues and summarize and report to the Infection Control committee.	F 880			
F 881 SS=E	Review of the 1/29/25 Bath- Shower/Tub - Level II policy failed to identify the procedure for cleaning and disinfecting the whirlpool tub according to manufacturer's guidelines following resident bathing. Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced	F 881			3/28/25

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F 881	Continued From page 14 by: Based on interview and document review, the facility failed to implement a comprehensive antibiotic stewardship program with antibiotic "Time Outs" (ATO) (formal review of a patient's antibiotic therapy that occurs 48-72 hours after the initial dose), or evaluation of continued need for antibiotic treatment for 3 of 3 residents (R6, R15 and R28). This has the potential to affect any resident receiving antibiotic treatment. Findings include: Interview and document review identified: R6's medical record (MR) identified a 1/18/24, physician (MD) order for Macrobid (an antibiotic used to treat urinary tract infections (UTIs)), 50 milligrams (mg) by mouth (PO) every (Q) evening (PM), for UTI prevention. The medical record failed to identify any urine cultures or sensitivity (UC/US) completed following the MD order, and no ATO for continued need of the medication. The record also failed to identify any non-pharmacological interventions attempted. R15's medical record identified a 1/21/25 MD orders for Macrobid 100 mg PO x 5 days for UTI. The record failed to include any criteria implemented nor was there documentation of an ATO completed. R28's medical record identified a 12/18/24 MD orders for Macrobid 100 mg PO twice daily (BID) x 10 days. The record failed to identify any criteria identified prior to initiation of the antibiotic. R28 developed a rash, and the antibiotic was changed on 12/29/24 to Ertapenem 1 gram (GM) intramuscularly (IM) x 5 days. A UA/UC was	F 881	1.It is the policy of this facility to abide by state and federal regulations related to antibiotic usage with an infection prevention and control program (IPCP) that must include, at a minimum, an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Develops and implements protocols to optimize the treatment of infections by ensuring that residents who require an antibiotic are prescribed the appropriate antibiotic; reduces the risk of adverse events, including the development of antibiotic-resistant organisms, from unnecessary or inappropriate antibiotic use, and develops, promotes, and implements a facility-wide system to monitor the use of antibiotics. This means that the antibiotic is prescribed for the correct indication, dose, and duration to appropriately treat the resident while also attempting to reduce the development of antibiotic-resistant organisms. The policy labeled "Appleton Area Health Antibiotic Stewardship Policy for LTC" states, antibiotic "time-out" at 72 hours after antibiotic initiation or first dose in the facility, each resident will be reassessed for consideration of antibiotic need, duration, selection, and de-escalation potential. At this time, laboratory testing results, response to therapy, resident condition, and facility needs (e.g. outbreak situation) will be considered. Completion of an antibiotic time-out must be recorded in the resident record. The facility failed to implement a comprehensive antibiotic		

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F 881	Continued From page 15 completed, and Ertapenem 1 gm IM X 10 days was reordered. A UA/UC was again completed on 1/27/25 with negative results. R28 received antibiotics from 12/29/24 through 1/23/25 with no criteria documented prior to requesting a UA and antibiotics and ATOs were not completed during this time. Interview on 1/27/25 at 5:00 p.m. with the director of nursing (DON), reported the infection preventionist (IP) had emailed her the information to provide, reported there was not consistent documentation of criteria used for updating the provider prior to requesting an antibiotic for a UTI, nor were ATO being completed. The DON identified there had been a meeting on 1/24/25 with the DON, ADON, IP, medical director, in-house pharmacist, and a nurse practioner(NP) to discuss antibiotic stewardship, criteria to be utilized for updating the provider of a resident with a potential UTI, ATOs, and the development of individualized care plans for those residents who demonstrated S/S outside the parameters and the inclusion of that information on the Standing Order Set. There was nothing implemented prior to the survey after it was identified. Interview on 1/27/25 at 5:43 p.m., with the medical director identified he had attended the meeting on 1/24/25 with discussion of guidelines for antibiotic stewardship and what criteria was to be use in the facility. He reported they had discussed current trends, with antibiotic use, and criteria such as Loeb's, or McGeer's to include in determining the use of antibiotics. He identified his agreement for review and documentation of a resident that had orders for a prophylactic antibiotic for a UTI and it should not just be assumed that an ongoing order was sufficient.	F 881	stewardship program with antibiotic "Time Outs" (ATO) (formal review of patient's antibiotic therapy that occurs 48-72 hours after the initial dose), or evaluation of continued need for antibiotic treatment for 3 of 3 residents (R6, R15 and R28). No residents were negatively affected by the cited deficiency. 2.All residents receiving antibiotic therapy have the potential to be affected by the cited deficiency related to the deficient practice of not completing the antibiotic time out. 3.To enhance the Care Center antibiotic stewardship program and under the direction of the Director of Nursing, and the interdisciplinary team have collaboratively identified the RCA of the cited deficiency. In addition to the following: a. An antibiotic timeout policy will be created by 3/28/2025. b. Nurses and Providers will be informed of the policy and sign off on the understanding of the policy by 3/28/2025. c. The Assistant Director of Nursing or designee is responsible for the antibiotic timeout forms. d. Newly prescribed antibiotics are tracked during daily stand up report.		

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F 881	Continued From page 16 ATO should be completed. Interview on 1/29/25 at 8:45 a.m., with the IP reported she attended morning meetings which included discussion of infections, wounds, changes in resident status, laboratory tests completed. She reported she would then follow up by checking EPIC (medical record application) for any new infections, labs, then follow up for orders for UTIs and C/S. She was aware two residents were currently receiving prophylactic antibiotics. The IP stated the nursing staff was going to use Loeb's as the criteria for requesting UA/UC, and her understanding was they had the criteria posted at the nursing station. She was not aware it was not being utilized, and ATO were not currently being completed and documented according to facility policy. Review of the September 15, 2022, Antibiotic Stewardship Policy for Long Term Care Identified the need for treatment of infections with the promotion of appropriate use of antibiotics. A monthly tracking report was to include summary of data collected with review by the consulting pharmacist, and IP with reports to the Quality Assurance Committee. Areas to be identified with antibiotic orders included: Resident name, antibiotic name, indication for the medication, route, dose, length of treatment, who prescribed the order, Antibiotic time out-yes/no, the record was to be reviewed, and information recorded in the e Excel database with review by the consulting pharmacist. ATO were to be collected and reported monthly for all antibiotics ordered whether from an outside or inside facility source.	F 881	4. Director of Nursing, Assistant Director of Nursing or designee will audit all newly prescribed antibiotics for completion of an ATO 2x/week x 1 week. Audit results will be brought to the QAPI committee for review and action, as appropriate. The QAPI committee will determine the need for further audits and/or action plan.		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs		PROVIDER # 245231	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	DATE SURVEY COMPLETE: 1/31/2025
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			
K 920	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, section 400.8. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/31/2025 between 9:15 and 11:45 AM, it was revealed by observation that there was a brown extension cord in the South Med Room behind the nurses station plugged into a fan. Violation was corrected at the time of discovery. An interview with Maintenance Staff verified this deficient finding at the time of discovery.			

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

The above isolated deficiencies pose no actual harm to the residents

031099

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If continuation sheet 1 of 1

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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 01/31/2025. 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		02/20/2025

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.

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

PRINTED: 02/24/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245231	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/31/2025
NAME OF PROVIDER OR SUPPLIER APPLETON AREA HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 30 S BEHL ST APPLETON, MN 56208		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 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 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 42 beds and had a census of 32 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K 000			
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the means of egress per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, and 7.1.10.1. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 01/31/2025 between 9:15 and 11:45 AM, it was revealed by observation that the exit corridor			K 211	EVS/Safety Manager, Butch Olson removed all boxes from hallway in front of CSR and informed CSR staff that no boxes are to be stored in the hallway. Communication posted for staff that hallways should not be obstructing any exits. To ensure compliance with deficiency tag EVS/Safety Manager, LNHA, DON or designee will audit the CSR hallway for compliance 2x/month for 3 months. Audit results will be brought to		1/31/25

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K 211	Continued From page 3 leading from the central supply room to the exit in the lower level was obstructed with the storage of several boxes of supplies.	K 211	the QAPI committee for review and action, as appropriate. The QAPI committee will determine the need for further audits.		
K 223 SS=F	An interview with Maintenance Staff verified this deficient finding at the time of discovery. Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain doors with self-closing devices per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2.7, and 7.2.1.8.1. These deficient findings could have a widespread impact on residents within the facility. Findings include: On 01/31/2025 between 9:15 and 11:45 AM, it was revealed by observation that the following self-closing fire doors were blocked in an open	K 223	EVS/Safety Manager, Butch Olson removed doorstops on kitchen door, clean linen door, chain on pump room, and replaced rug that dietary door was getting stuck on. All doors will remain closed and will not be propped open. Communication posed for staff says that doors should never be propped open. To ensure compliance with the deficiency tag EVS/Safety Manager, LNHA, DON or designee will audit these locations for compliance 2x/month for 3 months. Audit	1/31/25	

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K 223	Continued From page 4 position: 1. Door to the Clean Linen area in the basement laundry room. 2. Door to the basement Pump Room was held open by a chain. Violation was corrected at the time of discovery. 3. Both doors to the main kitchen were blocked open. One was blocked by a door wedge, the other was blocked open by a floor rug.	K 223	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 345 SS=D	An interview with Maintenance Staff verified these deficient findings at the time of discovery. Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1 and 9.6.1.5, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.4.5.3.2, and 14.6.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 345	EVS/Safety Manager, Butch Olson contacted Johnson Controls about smoke detector sensitivity testing being completed on smoke detectors in the facility. The Customer Care Representative, Kelly Neill, stated our facilities inspection report notes that this facility is sprinklered and smoke detector sensitivity is monitored and controlled through the FACP. The inspection supervisor says that the panel constantly monitors the sensitivity of the detectors.	2/20/25	

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K 345	Continued From page 5 On 01/31/2025 between 9:15 and 11:45 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation of smoke detector sensitivity testing being completed on the smoke detectors in the facility. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	Typically, they are set at 3.5%. When it reaches 2.5% obscurity, there will be a pre-alarm. Anything over 3.5% will trigger a full alarm. The panel will also indicate if the detector is "dirty". You should not need a manual sensitivity test. Testing is completed annually. Attached is the report from April 2024. Testing will be completed again in April 2025.		
K 353 SS=E	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 by: Based on observation and staff interview, the facility failed to inspect the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition),	K 353		2/7/25	
			EVS/Safety Manager, Butch Olson filled holes with fire caulking 2/7/2025. EVS/Safety Manager, Butch Olson and IT Manager, Brandon Norman will instruct		

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K 353	Continued From page 6 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1.2(2) and (5), and 5.2.2.2. These deficient findings could have a patterned impact on residents within the facility. Findings include: 1. On 01/31/2025 between 9:15 and 11:45 AM, it was revealed by observation that sprinkler heads in the main kitchen near the cooking equipment were covered and lint and debris. There were also sprinkler heads in the kitchen showing signs of corrosion. 2. On 01/31/2025 between 9:15 and 11:45 AM, it was revealed by observation that white IT wires were resting on the sprinkler pipe above the ceiling near the smoke barrier by the Director of Nursing office. An interview with Maintenance Staff verified these deficient findings at the time of discovery.	K 353	contractors to adhere to fire codes, that wires need to be secured so they're not touching any sprinklers, and that fire caulking is used to fill any holes created when running wires. To ensure compliance with deficiency tag EVS/Safety Manager, IT Manager or designee will check areas IT wires and/or electrical wires every time they're installed to ensure contractors secured wires away from sprinklers and that fire caulking has been used to fill any holes created. EVS/Safety Manager, Butch Olson cleaned sprinkler heads in the kitchen. Any corrosive heads will be replaced if unable to come clean. Communication posted for staff says all sprinkler heads should be clean, no corrosion and at least 18 inches from any obstruction. To ensure compliance with deficiency tag LNHA, DON or designee will audit all sprinkler heads in the care center for dust 1x/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 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered	K 363		2/7/25	

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K 363	Continued From page 7 smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.3 and 19.3.6.3.5. These deficient findings could have an isolated impact on the residents within the facility.			K 363	EVS/Safety Manager, Butch Olson fixed room 238, 249, and north shower doors so that they latch. Communication posted for care center staff to notify the maintenance department if any doors do not latch. To ensure compliance with deficiency tag EVS/Safety Manager,		

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K 363	Continued From page 8 Findings include: On 01/31/2025 between 9:15 and 11:45 AM , it was revealed by observation that the doors for the following rooms did not latch when closed: Room 238, Room 249, and the North Shower Room Door. An interview with Maintenance Staff verified these deficient findings at the time of discovery.	K 363	LNHA, DON or designee will audit these doors 2x/month for 3 months. Audit of all care center doors for latching by DON, ADON or designee 1x/quarter for 2 quarters to ensure compliance. 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 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 8.5.2.2, and 8.5.6.2. These deficient findings could have a patterned impact on the residents within the facility. Findings include:	K 372		2/7/25	

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K 372	Continued From page 9 On 01/31/2025 between 9:15 and 11:45 AM, it was revealed by observation that fire caulking was missing from several penetrations from white IT wires in the smoke barriers above the ceiling near the central dining room and the smoke barriers near the Director of Nursing office.	K 372	compliance with deficiency tag EVS/Safety Manager, IT Manager or designee will check areas IT wires and/or electrical wires every time they're installed to ensure contractors secured wires away from sprinklers and that fire caulking has been used to fill any holes created.	2/7/25	
K 923 SS=D	An interview with Maintenance Staff verified these deficient findings at the time of discovery. Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES)	K 923			

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K 923	Continued From page 10 STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper storage of gas cylinders per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.6.5.2. This deficient finding could have an isolated impact on residents within the faciilty. Findings include: On 01/31/2025 between 9:15 and 11:45 AM, it was revealed by observation that empty and full oxygen cylinders were stored in the West Oxygen Storage Room without being separated from each other. An interview with Maintenance Staff verified this deficient finding at the time of discovery.	K 923	Director of Nursing, Kris Payne separated used oxygen tanks from the full oxygen tanks. Signs were hung in the oxygen room where tanks need to be stored and education posted for staff to ensure compliance with deficiency tag EVS/Safety Manager, LNHA, DON or designee will audit the oxygen room for compliance 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.		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 1, 2025

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

RE: CCN: 245231
Cycle Start Date: January 29, 2025

Dear Administrator:

On March 31, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112