Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 11, 2024

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

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

Dear Administrator:

On November 22, 2023, we notified you a remedy was imposed. On January 10, 2024 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 29, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 1, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 22, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 1, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 29, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 15, 2023

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

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

Dear Administrator:

On November 1, 2023, a survey was completed at your facility by the Minnesota Departments 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 February 1, 2024 (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 May 1, 2024 (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) / 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,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 15, 2023

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

Re: Event ID: 3PC511

Dear Administrator:

The above facility survey was completed on November 1, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00655	A. BUILDING: _____ B. WING _____	C 11/01/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/1/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was reviewed:	2 000		

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2 000	Continued From page 1 H52316762C (MN00098038 and MN00098201). No licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		

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	245231	A. BUILDING _____ B. WING _____	C 11/01/2023

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F 000	INITIAL COMMENTS On 11/1/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed H52316762C (MN00098038 and MN00098201). Deficient practice was identified related to incidental finding at F609. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events	F 609		12/15/23

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

Electronically Signed | 11/22/2023

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

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F 609	Continued From page 1 that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to report an allegation of abuse timely to the State Agency for 1 of 1 resident (R1) reviewed for allegations of abuse. Findings include: An anonymous Vulnerable Adult Maltreatment Report submitted to the State Agency on 10/25/23, alleged staff to resident sexual abuse when it was reported a caregiver touched R1's genitals. R1's quarterly Minimum Data Set (MDS) dated 9/14/23, indicated R1 had diagnoses of dementia and Parkinson's disease. R1 had severe cognitive impairment, no hallucinations, and did not reject cares. The MDS also noted R1was dependent on staff for toileting hygiene, dressing,	F 609	1. It is the policy of this facility that all residents will be free from abuse, neglect, maltreatment, and misappropriation of resident property to abide by state and federal regulations. Ensuring all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The facility failed to immediately report an allegation of alleged sexual abuse within the 2 hours to the state agency for	

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F 609	Continued From page 2 and transfers. During an interview on 11/1/23 at 10:10 a.m., R1 indicated he had "an issue" with one staff but the staff person did not work with him anymore. R1 stated had already answered alot of questions and didn't want to answer anymore. During an interview on 11/1/23 at 11:10 a.m., family member (FM)-A indicated on 10//21/23, R1 reported he was having an "issue" with a NA that was touching him inappropriately at night, further explaining the staff person reached between his legs touched his privates [gentitals]. FM-A described R1 as being more alert and more clear than he had been on previous visits. FM-A further stated that although R1 has some confusion, R1 repeated the same allegation three (3) different times throughout the day. On 10/21/23, FM-A could not find a nurse to report the allegation to but, did report the allegation to a charge nurse (could not recall name of charge nurse) on 10/22/23. At that time FM-A was told they were already aware of the allegation. FM-A indicated the social worker (SW) called on 10/25/23 and told her that she was just made aware of the allegation of abuse and had moved R1 to a different room and "team" [of caregivers]. During an interview on 11/1/23 at 12:35 p.m., FM-B indicated she was aware of R1's allegation of inappropriate touching of the genitals and reported it to registered nurse (RN)-A on 10/21/23 and again on 10/22/23. During an interview on 11/1/23 at 11:45 a.m., the SW indicated R1's daughter reported the allegation of abuse on 10/25/23 at 11:50 a.m.. The SW further indicated R1 was interviewed by	F 609	resident R1 when R1's family reported concerns to nursing staff on 10/22/23. It was again reported to SSC on 10/25/23, interviews were conducted, and NA-A was immediately removed from the care of R1, and staff were told to always have 2 when caring for R1. The interdisciplinary team discussed the allegation after internal investigation was completed with a determination to file the sexual abuse allegation to state agency on 11/01/2023 at 1320. With information gathered from internal investigation the 5 day follow up report was submitted on 11/7/2023 at 1950. A surveyor was in the building during the complaint survey, investigated the allegation at the same time the facility was completing the internal investigation and OHFC report. 2. All current residents have potential to be affected by stated deficiency; no similar findings and/or negative effects have been identified by this alleged deficient practice. 3. To enhance currently compliant reporting requirements under the direction of the Director of Nursing a. The Interdisciplinary Team and Care Center Nursing staff were educated on the requirements of F609, Reporting of Alleged Violations at a staff meeting on February 6th and 7th, 2023 with a post-test requirement of 80% to pass or retake until 80% correct is achieved. As of 11/22/2023 100% have completed the education and passed the post-test requirement. b. All new hires will be educated by LNHA, DON or designee by use of a	

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F 609	Continued From page 3 the facility but he declined to dicuss the allegation and only provided concerns related to another staff he did not care to work with. As a result of the ongoing concerns with that staff and the allegation they immediately moved R1 to a different room which meant a different "team" of caregivers and implemented two staff for all personal cares. The SW stated she did not report the allegation to the SA because everything she was hearing was second hand and R1 did not tell her anything firsthand. Further stated she did not feel the allegation was reportable [to the SA]. During an interview on 11/1/23 at 12:00 p.m., the director of nursing (DON) indicated she had been on medical leave and returned on 10/31/23. She was made aware of the allegation on 10/31/23 but did not think it was reportable [to the SA]. During an interview on 11/1/23 at 12:25 p.m., the administrator indicated the SW reported the allegation of abuse to her on 10/25/23. Further indicated she wasn't aware that it was reportable but planned to report it immediately now that she was aware of the regulatory requirements. The Abuse, Neglect, Mistreatment and Misappropriation of Resident Property policy last revised 1/7/21, indicates it is the policy of the facility that "abuse" allegations are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse are reported immediately, but not later than 2 (two) hours after the allegations is made.	F 609	handout and review of the policy. After completion, staff will have to pass a written competency exam with 80% correct. If 80% is not achieved, the employee will have to review the information again, with repeat competency examination, until 80% correct is achieved. Annual education to be completed by Social Services Coordinator or designee and Health stream required annual training. c. The education focused on the facility's responsibility to ensure alleged violations involving abuse, neglect, maltreatment, and misappropriation of resident property are immediately reported to the Nurse, Administrator, DON and/or Social Services Coordinator and respective State Agency as indicated in timely manner. d. Staff were educated on Abuse/Neglect & Resident Rights by Ombudsman on 10/25/2023. e. Reporting allegations will be discussed at all nursing and aide meetings. f. Residents' right bingo will be completed by activities to ensure that residents are aware of their rights. Resident Rights are reviewed at resident/family council by Social Services Coordinator. g. The interdisciplinary team, nurses and aides are aware that any allegation brought forward by anyone needs to be reported immediately. This will also be reviewed at every nurse/aide meeting. h. The Interdisciplinary Team will conduct 3 random staff interviews weekly	

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F 609	Continued From page 4	F 609	x 4 weeks until 12/15/2023, then monthly for 3 months until 3/15/2024. The Interdisciplinary Team will conduct 3 random resident interviews weekly x 4 weeks until 12/15/2023, then monthly for 3 months until 3/15/2024. If allegations of abuse/neglect are determined during those interviews, they will report to SSC and DON to file report immediately. This will ensure the residents feel safe and that reporting of any allegations found during interviews is reported timely. The information will be brought to the QAPI committee to determine further needs of random interviews. 4. Interdisciplinary team under the direction of the Director of Nursing will review falls, incidents, and reports of suspected abuse at morning stand up and track if any of the incidents were reportable, if they were reported, and if reported in a timely manner. Findings will be brought to QAPI committee for review and action, as appropriate. The QAPI committee will determine the need for further action plan.	