DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 14, 2020

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

RE: CCN: 245231
Cycle Start Date: May 22, 2020

Dear Administrator:

On June 29, 2020, the Minnesota Department(s) of Health 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,

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

cc: Licensing and Certification File

Electronically delivered
June 5, 2020

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

SUBJECT: SURVEY RESULTS
CCN: 245231
Cycle Start Date: May 22, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On May 22, 2020, the Minnesota Department of Health completed a complaint investigation at Appleton Area Health to determine if your facility was in compliance with Federal requirements related to the complaint. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION

You must submit an acceptable electronic plan of correction (ePOC) for the enclosed deficiencies that were cited during the May 22, 2020 survey. Appleton Area Health may choose to delay submission of an ePOC until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit an ePOC. 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. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation.

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; and
- The date that each deficiency will be corrected.

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

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kathleen.lucas@state.mn.us
Fax: (320) 223-7348

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the May 22, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kathleen.lucas@state.mn.us
Fax: (320) 223-7348

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting

immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Appleton Area Health may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245231	A. BUILDING _____ B. WING _____	C 05/22/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/21/20-5/22/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5231015C. Deficiency cited at F Tag 689. 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		6/15/20

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

Electronically Signed | 06/15/2020

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F 689	Continued From page 1 Based on observation, interview, and document review, the facility failed to implement adequate supervision and safety measures to ensure residents were free from accident hazards, for 1 of 3 residents (R1) reviewed. This resulted in actual harm when R1 sustained a fall resulting in two fractures, while receiving therapy. Findings include: R1's admission record, dated 5/2/18, indicated R1 had diagnoses including dementia, chronic pain, dorsalgia (stinging or burning like sensation of pain in back or spine that radiates), tremors, vertigo (sensation of feeling off balance), and generalized osteoarthritis (degeneration of joint cartilage and the underlying bone). R1's Morse Fall Scale, completed 5/7/20, indicated R1 had history of falling, had impaired gait, overestimates or forgets limits, and was categorized as, "High Risk for Falling." R1's Safety Risk Assessment, completed 2/6/20, indicated R1 had a history of falls, had unsteady gait, chronic/acute condition making R1 unsteady, dizziness, balance problems, pain, loss of arm or leg movement, and decline in functional status. Also included, R1 was at risk for falls due to history of falls and declining cognition and mobility, and was no longer safe to transfer or ambulate on own. R1's quarterly Minimum Data Set (MDS), dated 5/21/20, indicated R1 had moderate cognitive impairment and required extensive assistance of two staff for bed mobility, transfers, walking in the room and corridor, dressing, and toilet use. The MDS also identified R1 was not steady, was only	F 689	1) Resident R1 has been assessed for safe mobility including transfers and ambulation. Big Stone Therapies took immediate action in reporting the incident and creating an action plan with the PTA who was assisting R1 during the fall. 2) All residents who work with physical therapy have been evaluated by a physical therapist who determines safe levels of practice for transfers and ambulation. PTAs are responsible for carrying out the treatment plan and progressing patients under the supervision of a Physical Therapist per standard of practice for Physical Therapy. 3) On 6/2/2020 Big Stone Therapies Manager completed competencies relating to resident transfers and ambulation with all Big Stone Physical Therapy Staff. The policy “Physical Therapy Fall Prevention” was created by Big Stone Therapies to guide safe practice for residents who are high risk for falls. All staff in the physical therapy department will have been educated and reviewed the new policy by 6/19/2020. 4) Big Stone Therapies Manager and Physical Therapist will audit PTA-A’s transfers and ambulation of residents. After one month, audits will be reduced to once weekly. If there are no concerns, audits will then be reduced to randomly for two additional months. Results of the audits will be reported to the QA committee each quarter. The QA Committee will determine when the	

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F 689	Continued From page 2 able to stabilize with human assistance during transitions and walking, and had functional limitation in range of motion in upper extremities on both sides. Also, included, R1 had no falls since the previous MDS assessment, completed 2/20/20 due to a significant change, which indicated one fall with no injury, two or more falls with injury, and one fall with major injury. R1's care plan, last revised 2/25/20, indicated R1 had a performance deficit with activities of daily living (ADL) due to declining cognition, essential tremors, decreased mobility, generalized weakness, and chronic back pain, and required extensive assistance of two staff, with gait belt and four wheeled walker for transfers, and extensive assistance of two to three staff, four wheeled walker and gait belt, followed by wheelchair, when ambulating. The care plan also indicated R1 was at risk for falls due to history of falls with injury, declining cognition, and mobility, and needed assistance to stabilize. Review of R1's physician orders included an order on 5/1/20 for physical therapy (PT)/occupational (OT) evaluation and treatment for ambulation, balance, and neck pain. R1's Physical Therapy PT Evaluation & Plan of Treatment, dated 5/8/20, indicated diagnosis of generalized muscle weakness, and identified treatment approaches including therapeutic exercises, neuromuscular reeducation, physical therapy evaluation, and therapeutic activities twice weekly for six weeks. Long-Term goals identified R1 would demonstrate ability to perform sit to stand from recliner with minimal assist of one, improvement in bilateral lower extremity strength in order to improve stability in stance, be	F 689	deficiency has been corrected and audits can cease. All Big Stone Physical Therapy Staff demonstrated competency in transfers and ambulation of residents on 6/2/2020. Review of the new policy will be added to the new hire checklist for Big Stone Therapies physical therapy department.	

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F 689	Continued From page 3	F 689		

able to stand without upper extremity support for at least 30 seconds without loss of balance, and would be able to ambulate at least 200 feet with CGA (contact guard assist-physical therapist needs to have one or two hands on patients body to help steady body or help with balance) to minimal assist with rolling walker and cues for anterior weight shift less than 25% of time.

Review of the Physical Therapy Treatment Encounter Note(s), dated 5/14/20, indicated, "Once standing [R1] is able to maintain balance with only CGA for several minutes." Also indicated, all activities with CGA to minimal assist at all times to avoid loss of balance, and R1 had most difficulty with retrobalance (loss of balance in backwards direction) requiring minimal assist to avoid loss of balance. Physical Therapy Treatment Encounter Note(s), dated 5/15/19, included R1 reported his legs were "really sore today," and staff reported R1's "knees buckled" during a transfer after PT on 5/14/20, and it took three staff to keep R1 from falling. Physical Therapy Treatment Encounter Note(s), dated 5/18/20, included, R1 completed "standing glute sets," on parallel bars, CGA on gait belt. "PTA [physical therapy assistant] positioned in front of pt [patient]; pt sustains falls when PTA steps back to switch position to side of patient." Also included, "During standing glute sets pt sustains fall backward when PTA lets go momentarily to switch positions with pt having BIL [bilateral] HHA [hand hold assist] on bars. Patient was wearing a gait belt and until the fall PTA had been in CGA with pt."

During an observation on 5/21/20, at 2:00 p.m. R1 was lying in the bed, resting. A sling was noted on R1's right arm/shoulder, and R1

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indicated he had to wear a boot on his right foot. R1 stated, "[PTA-A] was walking me and went to switch sides. I fell back." R1 stated he just wanted to get stronger so he can walk and indicated he wasn't sure what happened, he just felt himself go backwards and he hit the floor. R1 indicated he had a gait belt on and stated with tears in eyes, "[PTA-A] felt bad, but she didn't do it. It was me. I should be able to stand."

Review of the Patient Incident/Injury Report Form, dated 5/18/20, at 1:10 p.m. included R1 was working with PTA-A in the parallel bars in the facility rehabilitation room, positioned in front of him holding the gait belt, and R1 was holding onto each side of the parallel bars. PTA-A let go and stepped back as she was going to change position to stand at R1's side. R1 had loss of balance backwards and fell to the floor when PTA-A let go of the gait belt.

Review of the Appleton Area Health documentation, dated 5/18/20, included X-ray results indicated R1 sustained a nondisplaced fracture of right fibula (long, thin and lateral bone of the lower leg) and nondisplaced fracture of right humeral neck (long bone of the upper arm that extends from shoulder to elbow) when he fell, and CT (computerized tomography) scan of the brain indicated no intracranial hemorrhage (bleeding in head) or cranial fractures.

During an interview on 5/21/20, at 9:55 a.m. PTA-A stated she was working with R1 due to him having poor balance and history of falls. PTA-A stated, on 5/18/20, she ambulated with R1 from his room, into the hallway. R1 wore a gait belt, used a four wheeled walker, and nursing assistant (NA)-A and restorative aide (RA)-A

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assisted. PTA-A stated, after approximately 75 feet, R1 wanted to sit in the wheelchair. R1 was pushed into the rehabilitation room and PTA-A allowed him to rest. RA-A and NA-A left the room to help another resident. After resting, PTA-A stated she assisted R1 to stand and positioned him inside the parallel bars. PTA-A stated she was standing in front of R1, holding the gait belt, having R1 perform different exercises. PTA-A stated R1 was in the middle of the parallel bars, and she let go of the gait belt momentarily to step around to R1's side, outside of the parallel bars. R1 fell backwards to the floor. PTA-A stated she should have had R1 sit prior to letting go of the gait belt, however, she had let R1's gait belt go in prior sessions and he had never let go of the parallel bars. PTA-A stated the first time she walked with R1 on 5/14/20, he was "super staggering and unsteady." On 5/18/20, PTA-A stated, when she and NA-A and RA-A walked R1, he was not nearly as unsteady. PTA-A stated, "I thought he was improving. I felt he was stable enough for me to walk around him." PTA-A stated, after R1's fall, her manager talked to her and, "Going forward, if someone is unsteady or a balance patient, I would have a second person to steady, or I could have him sit first and then switch positions."

During an interview on 5/21/20, at 10:14 a.m. physical therapist (PT) indicated he and PTA-A worked for a therapy agency, and they were contracted to provide therapy services to residents at the facility. PT stated he oversees PTA-A and had talked with her about R1's fall. PT stated he assumed, by PTA-A's description, that she had R1 in the parallel bars, working on balance, and probably had him standing in the middle, and then went out of the parallel bars to

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change positions when R1 fell. While in the rehabilitation room, PT demonstrated how he would work with a resident in the parallel bars, indicating he would typically have the wheelchair close, and would have the resident sit while he switched positions. PT stated he had not provided any re-education for PTA-A, because she had a manager that was responsible for doing that.

When interviewed on 5/21/20, at 10:27 a.m. registered nurse (RN)-A stated she was out in the hallway when RA-A came to say that R1 was on the floor. When RN-A got to the rehabilitation room, R1 was lying within the parallel bars, parallel to the bars. R1 had a skin tear on the left elbow and was complaining of pain in his back and right shoulder. R1 was lifted off the floor with a full body lift, assessed, and R1's health care provider was notified. R1 was sent to the emergency room that was attached to the nursing home, via wheelchair, for further assessment. RN-A stated R1's balance "waxes and wanes," and he required assistance of two when transferring due to his unsteadiness. RN-A stated she had only worked at the facility a short time, but stated, "I know they used to transfer him with one assist but recently he seemed more unsteady so we were using two. He was more shaky and tired, depending on the time of day."

During an interview on 5/21/20, at 10:39 a.m. RA-A stated he had been working with R1 for upper and lower extremity strengthening, and in the past five months, R1 had gained strength in his lower extremities, however, RA-A stated his balance and strength still "depended on the day," and "time of day," and stated R1 always required assist of two staff in the morning with cares due to being more weak and groggy. RA-A stated R1

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was always more alert and oriented in the afternoon, so that was the best time to work with him. On the day that R1 fell, RA-A stated it was around 1:00 in the afternoon, and R1 agreed to work with PTA-A. R1's gait belt was put on, and PTA-A and NA-A assisted R1 to ambulate into the hallway, with RA-A following with a wheelchair. R1 walked part way and became tired, so he was pushed by wheelchair into the rehabilitation room. RA-A stated staff from therapy normally worked with R1 alone, and RA-A stated he left the room to assist with another resident. When RA-A walked back by the rehabilitation room, R1 was lying on the floor, and was complaining of pain in his right shoulder and was crying. RA-A indicated he assisted to lift R1 off the floor with the full body lift and transported R1 to the emergency department in his wheelchair. RA-A stated, "We always have two staff with transfers. He is that unsteady. If we were to let go, he tends to go back. I assumed that everyone knew that. The main thing is don't let him go backwards...I have worked with him many times in those parallel bars and never had an incident, but I never let go."

When interviewed on 5/21/20, at 1:30 p.m. director of nursing (DON) stated R1 had "gone back and forth" with therapy, would get stronger and do well, and then would become ill and would require physical therapy again. DON stated R1 had made so much progress and was getting stronger, however, "We continued to use two assists because his strength is so variable." DON indicated he had no concerns with PTA-A and stated, "She's so good. She's so concerned with safety. She just got too comfortable maybe, feeling that he could hold the bars briefly so she could switch positions."

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During an interview on 5/21/20, at 1:37 p.m. RN-B stated, after a fall with fracture to his left humerus in December, R1 had really gained some strength back, and as of late, was doing well, however, R1's strength had been "variable," and required two assist for ambulation and transfers. RN-B indicated R1 had several falls in the past due to self transferring. RN-B stated PTA-A was working with R1, by herself, when the fall occurred. When completing the investigation after the fall, RN-B indicated PTA-A reported R1 had been gaining strength and PTA-A was so confident in his progress that she felt she could let go of him briefly to switch positions. RN-B stated she told PTA-A that the nursing assistants always used two assists for ambulation and transfers. RN-B stated there were never safety concerns when PTA-A worked with residents, and there had never been any prior incidents with PTA-A or therapy in general.

When interviewed on 5/21/20, at 6:01 p.m. PTA-B stated she was the clinic manager for Big Stone Therapies, and was PTA-A's manager/supervisor. PTA-B stated a PT is at the facility three days a week and oversees PTA-A. PTA-B stated she received a phone call from PTA-A immediately after R1 fell. PTA-A reported R1 was in the parallel bars, working on some things, and PTA-A was in front of R1. PTA-A was going to move out of R1's way, and the next thing she knew, R1 was on the floor. PTA-B stated she had worked with R1 a few months ago, and stated, "He does have a tendency to lose this balance." PTA-B stated, "We talked about the situation and what she should have done or could have done differently...having him sit, move wheelchair closer, having someone assist." PTA-B stated,

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 9	F 689		

"We don't typically have two staff to assist with therapy, and with COVID, we're trying to keep the exposure down. Therapists are treating all patients by themselves." PTA-B stated, "My expectation would be, that in the future, to look at the patient that we're treating."

During a follow up interview on 5/22/20, at 10:40 a.m. PT stated, "When in parallel bars, with [R1's] fall risk and posterior loss of balance, [R1] should have contact guard assist," and stated, "Contact guard assist means having your hand on the patient while walking." PT stated, "There comes a period of time where less support is needed, based on judgement...I make that judgement by testing it and being right there to catch the patient...We are trying to progress the patient and when we have our hands on them all the time, it gives them a false sense of security." PT stated he and PTA-A discuss patients' status all the time. PT-A stated, "I do believe she should have had her hand on [R1]. I don't know what lead up to that decision. It's unfortunate, she's very good at what she does."

Review of the facility's policy, Using the Care Plan, dated 7/19, included, "The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident."

Review of the facility's policy, Falls and Fall Risk-Managing, dated 7/19, included, "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling."

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	245231	A. BUILDING _____ B. WING _____	C 05/22/2020

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Electronically delivered
June 5, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: 5UQI11

Dear Administrator:

The above facility was surveyed on May 21, 2020 through May 22, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

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.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/21/20-5/22/20, surveyor of this Department's staff visited the above provider for an abbreviated survey complaint investigation to investigate complaint: H5231015C The following correction orders are issued. Please indicate your electronic plan of correction	2 000		

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2 000	Continued From page 1 that you have reviewed these order, and identify the date when they will be corrected.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement adequate supervision and safety measures to ensure residents were free from accident hazards, for 1 of 3 residents (R1) reviewed. This resulted in actual harm when R1 sustained a fall resulting in two fractures, while receiving therapy. Findings include: R1's admission record, dated 5/2/18, indicated R1 had diagnoses including dementia, chronic pain, dorsalgia (stinging or burning like sensation of pain in back or spine that radiates), tremors, vertigo (sensation of feeling off balance), and generalized osteoarthritis (degeneration of joint	2 830	Acknowledged. See tag F689 plan of correction.	6/15/20

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2 830	Continued From page 2 cartilage and the underlying bone). R1's Morse Fall Scale, completed 5/7/20, indicated R1 had history of falling, had impaired gait, overestimates or forgets limits, and was categorized as, "High Risk for Falling." R1's Safety Risk Assessment, completed 2/6/20, indicated R1 had a history of falls, had unsteady gait, chronic/acute condition making R1 unsteady, dizziness, balance problems, pain, loss of arm or leg movement, and decline in functional status. Also included, R1 was at risk for falls due to history of falls and declining cognition and mobility, and was no longer safe to transfer or ambulate on own. R1's quarterly Minimum Data Set (MDS), dated 5/21/20, indicated R1 had moderate cognitive impairment and required extensive assistance of two staff for bed mobility, transfers, walking in the room and corridor, dressing, and toilet use. The MDS also identified R1 was not steady, was only able to stabilize with human assistance during transitions and walking, and had functional limitation in range of motion in upper extremities on both sides. Also, included, R1 had no falls since the previous MDS assessment, completed 2/20/20 due to a significant change, which indicated one fall with no injury, two or more falls with injury, and one fall with major injury. R1's care plan, last revised 2/25/20, indicated R1 had a performance deficit with activities of daily living (ADL) due to declining cognition, essential tremors, decreased mobility, generalized weakness, and chronic back pain, and required extensive assistance of two staff, with gait belt and four wheeled walker for transfers, and extensive assistance of two to three staff, four	2 830		

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2 830	Continued From page 3 wheeled walker and gait belt, followed by wheelchair, when ambulating. The care plan also indicated R1 was at risk for falls due to history of falls with injury, declining cognition, and mobility, and needed assistance to stabilize. Review of R1's physician orders included an order on 5/1/20 for physical therapy (PT)/occupational (OT) evaluation and treatment for ambulation, balance, and neck pain. R1's Physical Therapy PT Evaluation & Plan of Treatment, dated 5/8/20, indicated diagnosis of generalized muscle weakness, and identified treatment approaches including therapeutic exercises, neuromuscular reeducation, physical therapy evaluation, and therapeutic activities twice weekly for six weeks. Long-Term goals identified R1 would demonstrate ability to perform sit to stand from recliner with minimal assist of one, improvement in bilateral lower extremity strength in order to improve stability in stance, be able to stand without upper extremity support for at least 30 seconds without loss of balance, and would be able to ambulate at least 200 feet with CGA (contact guard assist-physical therapist needs to have one or two hands on patients body to help steady body or help with balance) to minimal assist with rolling walker and cues for anterior weight shift less than 25% of time. Review of the Physical Therapy Treatment Encounter Note(s), dated 5/14/20, indicated, "Once standing [R1] is able to maintain balance with only CGA for several minutes." Also indicated, all activities with CGA to minimal assist at all times to avoid loss of balance, and R1 had most difficulty with retrobalance (loss of balance in backwards direction) requiring minimal assist to avoid loss of balance. Physical Therapy	2 830		

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2 830	Continued From page 4 Treatment Encounter Note(s), dated 5/15/19, included R1 reported his legs were "really sore today," and staff reported R1's "knees buckled" during a transfer after PT on 5/14/20, and it took three staff to keep R1 from falling. Physical Therapy Treatment Encounter Note(s), dated 5/18/20, included, R1 completed "standing glute sets," on parallel bars, CGA on gait belt. "PTA [physical therapy assistant] positioned in front of pt [patient]; pt sustains falls when PTA steps back to switch position to side of patient." Also included, "During standing glute sets pt sustains fall backward when PTA lets go momentarily to switch positions with pt having BIL [bilateral] HHA [hand hold assist] on bars. Patient was wearing a gait belt and until the fall PTA had been in CGA with pt." During an observation on 5/21/20, at 2:00 p.m. R1 was lying in the bed, resting. A sling was noted on R1's right arm/shoulder, and R1 indicated he had to wear a boot on his right foot. R1 stated, "[PTA-A] was walking me and went to switch sides. I fell back." R1 stated he just wanted to get stronger so he can walk and indicated he wasn't sure what happened, he just felt himself go backwards and he hit the floor. R1 indicated he had a gait belt on and stated with tears in eyes, "[PTA-A] felt bad, but she didn't do it. It was me. I should be able to stand." Review of the Patient Incident/Injury Report Form, dated 5/18/20, at 1:10 p.m. included R1 was working with PTA-A in the parallel bars in the facility rehabilitation room, positioned in front of him holding the gait belt, and R1 was holding onto each side of the parallel bars. PTA-A let go and stepped back as she was going to change position to stand at R1's side. R1 had loss of balance backwards and fell to the floor when	2 830		

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2 830	Continued From page 5 PTA-A let go of the gait belt. Review of the Appleton Area Health documentation, dated 5/18/20, included X-ray results indicated R1 sustained a nondisplaced fracture of right fibula (long, thin and lateral bone of the lower leg) and nondisplaced fracture of right humeral neck (long bone of the upper arm that extends from shoulder to elbow) when he fell, and CT (computerized tomography) scan of the brain indicated no intracranial hemorrhage (bleeding in head) or cranial fractures. During an interview on 5/21/20, at 9:55 a.m. PTA-A stated she was working with R1 due to him having poor balance and history of falls. PTA-A stated, on 5/18/20, she ambulated with R1 from his room, into the hallway. R1 wore a gait belt, used a four wheeled walker, and nursing assistant (NA)-A and restorative aide (RA)-A assisted. PTA-A stated, after approximately 75 feet, R1 wanted to sit in the wheelchair. R1 was pushed into the rehabilitation room and PTA-A allowed him to rest. RA-A and NA-A left the room to help another resident. After resting, PTA-A stated she assisted R1 to stand and positioned him inside the parallel bars. PTA-A stated she was standing in front of R1, holding the gait belt, having R1 perform different exercises. PTA-A stated R1 was in the middle of the parallel bars, and she let go of the gait belt momentarily to step around to R1's side, outside of the parallel bars. R1 fell backwards to the floor. PTA-A stated she should have had R1 sit prior to letting go of the gait belt, however, she had let R1's gait belt go in prior sessions and he had never let go of the parallel bars. PTA-A stated the first time she walked with R1 on 5/14/20, he was "super staggering and unsteady." On 5/18/20, PTA-A stated, when she and NA-A and RA-A walked R1,	2 830		

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2 830	Continued From page 6 he was not nearly as unsteady. PTA-A stated, "I thought he was improving. I felt he was stable enough for me to walk around him." PTA-A stated, after R1's fall, her manager talked to her and, "Going forward, if someone is unsteady or a balance patient, I would have a second person to steady, or I could have him sit first and then switch positions." During an interview on 5/21/20, at 10:14 a.m. physical therapist (PT) indicated he and PTA-A worked for a therapy agency, and they were contracted to provide therapy services to residents at the facility. PT stated he oversees PTA-A and had talked with her about R1's fall. PT stated he assumed, by PTA-A's description, that she had R1 in the parallel bars, working on balance, and probably had him standing in the middle, and then went out of the parallel bars to change positions when R1 fell. While in the rehabilitation room, PT demonstrated how he would work with a resident in the parallel bars, indicating he would typically have the wheelchair close, and would have the resident sit while he switched positions. PT stated he had not provided any re-education for PTA-A, because she had a manager that was responsible for doing that. When interviewed on 5/21/20, at 10:27 a.m. registered nurse (RN)-A stated she was out in the hallway when RA-A came to say that R1 was on the floor. When RN-A got to the rehabilitation room, R1 was lying within the parallel bars, parallel to the bars. R1 had a skin tear on the left elbow and was complaining of pain in his back and right shoulder. R1 was lifted off the floor with a full body lift, assessed, and R1's health care provider was notified. R1 was sent to the emergency room that was attached to the nursing home, via wheelchair, for further assessment.	2 830		

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2 830	Continued From page 7 RN-A stated R1's balance "waxes and wanes," and he required assistance of two when transferring due to his unsteadiness. RN-A stated she had only worked at the facility a short time, but stated, "I know they used to transfer him with one assist but recently he seemed more unsteady so we were using two. He was more shaky and tired, depending on the time of day." During an interview on 5/21/20, at 10:39 a.m. RA-A stated he had been working with R1 for upper and lower extremity strengthening, and in the past five months, R1 had gained strength in his lower extremities, however, RA-A stated his balance and strength still "depended on the day," and "time of day," and stated R1 always required assist of two staff in the morning with cares due to being more weak and groggy. RA-A stated R1 was always more alert and oriented in the afternoon, so that was the best time to work with him. On the day that R1 fell, RA-A stated it was around 1:00 in the afternoon, and R1 agreed to work with PTA-A. R1's gait belt was put on, and PTA-A and NA-A assisted R1 to ambulate into the hallway, with RA-A following with a wheelchair. R1 walked part way and became tired, so he was pushed by wheelchair into the rehabilitation room. RA-A stated staff from therapy normally worked with R1 alone, and RA-A stated he left the room to assist with another resident. When RA-A walked back by the rehabilitation room, R1 was lying on the floor, and was complaining of pain in his right shoulder and was crying. RA-A indicated he assisted to lift R1 off the floor with the full body lift and transported R1 to the emergency department in his wheelchair. RA-A stated, "We always have two staff with transfers. He is that unsteady. If we were to let go, he tends to go back. I assumed that everyone knew that. The main thing is don't	2 830		

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2 830	Continued From page 8 let him go backwards...I have worked with him many times in those parallel bars and never had an incident, but I never let go." When interviewed on 5/21/20, at 1:30 p.m. director of nursing (DON) stated R1 had "gone back and forth" with therapy, would get stronger and do well, and then would become ill and would require physical therapy again. DON stated R1 had made so much progress and was getting stronger, however, "We continued to use two assists because his strength is so variable." DON indicated he had no concerns with PTA-A and stated, "She's so good. She's so concerned with safety. She just got too comfortable maybe, feeling that he could hold the bars briefly so she could switch positions." During an interview on 5/21/20, at 1:37 p.m. RN-B stated, after a fall with fracture to his left humerus in December, R1 had really gained some strength back, and as of late, was doing well, however, R1's strength had been "variable," and required two assist for ambulation and transfers. RN-B indicated R1 had several falls in the past due to self transferring. RN-B stated PTA-A was working with R1, by herself, when the fall occurred. When completing the investigation after the fall, RN-B indicated PTA-A reported R1 had been gaining strength and PTA-A was so confident in his progress that she felt she could let go of him briefly to switch positions. RN-B stated she told PTA-A that the nursing assistants always used two assists for ambulation and transfers. RN-B stated there were never safety concerns when PTA-A worked with residents, and there had never been any prior incidents with PTA-A or therapy in general. When interviewed on 5/21/20, at 6:01 p.m. PTA-B	2 830		

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2 830	Continued From page 9 stated she was the clinic manager for Big Stone Therapies, and was PTA-A's manager/supervisor. PTA-B stated a PT is at the facility three days a week and oversees PTA-A. PTA-B stated she received a phone call from PTA-A immediately after R1 fell. PTA-A reported R1 was in the parallel bars, working on some things, and PTA-A was in front of R1. PTA-A was going to move out of R1's way, and the next thing she knew, R1 was on the floor. PTA-B stated she had worked with R1 a few months ago, and stated, "He does have a tendency to lose this balance." PTA-B stated, "We talked about the situation and what she should have done or could have done differently...having him sit, move wheelchair closer, having someone assist." PTA-B stated, "We don't typically have two staff to assist with therapy, and with COVID, we're trying to keep the exposure down. Therapists are treating all patients by themselves." PTA-B stated, "My expectation would be, that in the future, to look at the patient that we're treating." During a follow up interview on 5/22/20, at 10:40 a.m. PT stated, "When in parallel bars, with [R1's] fall risk and posterior loss of balance, [R1] should have contact guard assist," and stated, "Contact guard assist means having your hand on the patient while walking." PT stated, "There comes a period of time where less support is needed, based on judgement...I make that judgement by testing it and being right there to catch the patient...We are trying to progress the patient and when we have our hands on them all the time, it gives them a false sense of security." PT stated he and PTA-A discuss patients' status all the time. PT-A stated, "I do believe she should have had her hand on [R1]. I don't know what lead up to that decision. It's unfortunate, she's very good at what she does."	2 830		

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 05/22/2020

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

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2 830	Continued From page 10 Review of the facility's policy, Using the Care Plan, dated 7/19, included, "The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident." Review of the facility's policy, Falls and Fall Risk-Managing, dated 7/19, included, "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling." SUGGESTED METHOD OF CORRECTION: The director of Therapy or designee, could review/revise policies and procedures related to fall precautions and when working with patients assessed as high risk for falling. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 830		