

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



Protecting, Maintaining and Improving the Health of All Minnesotans

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

Appleton Area Health June 5, 2020 Page 2

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

Appleton Area Health June 5, 2020 Page 3

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

Towers Stapson

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

PRINTED: 06/16/2020 FORM APPROVED OMB NO. 0938-0391

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F 000	INITIAL COMMEN	TS	F 0	00			
	completed at your tinvestigation. Your	0, an abbreviated survey was facility to conduct a complaint facility was found not to be in 2 CFR Part 483, Requirements a Facilities.					
	The following compsubstantiated:	plaint was found to be					
	H5231015C. Defic	iency cited at F Tag 689.					
	as your allegation of Department's acceenrolled in ePOC, year the bottom of the	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required the first page of the CMS-2567 nic submission of the POC will tion of compliance.					
F 689	on-site revisit of yo validate that substate regulations has been your verification. Free of Accident H	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with azards/Supervision/Devices	F 6	89		6/15/20	
SS=G	§483.25(d) Accider The facility must er §483.25(d)(1) The	nts.					
	supervision and as accidents.	resident receives adequate sistance devices to prevent					
L ABORATOR'	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE	

Electronically Signed 06/15/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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.

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE DELAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		E SURVEY PLETED			
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	Continued From p Based on observa review, the facility supervision and sa residents were free of 3 residents (R1) actual harm when two fractures, whill Findings include: R1's admission re- R1 had diagnoses pain, dorsalgia (sti of pain in back or severtigo (sensation generalized osteoa cartilage and the u R1's Morse Fall So indicated R1 had it gait, overestimates categorized as, "H R1's Safety Risk A indicated R1 had a	age 1 ation, interview, and document failed to implement adequate afety measures to ensure e from accident hazards, for 1 oreviewed. This resulted in R1 sustained a fall resulting in e receiving therapy. cord, dated 5/2/18, indicated including dementia, chronic inging or burning like sensation spine that radiates), tremors, of feeling off balance), and arthritis (degeneration of joint		CROSS-REFERENCED TO THE DEFICIENCY)	assessed for fers and apies took g the incident with the PTA g the fall. with physical d by a mines safe and onsible for lan and the herapist per sical Therapy. Therapies tencies and e Physical as created by le safe re high risk for	
	dizziness, balance leg movement, an Also included, R1 history of falls and	problems, pain, loss of arm or d decline in functional status. was at risk for falls due to declining cognition and no longer safe to transfer or		department will have been en reviewed the new policy by 4) Big Stone Therapies Management Physical Therapist will audit transfers and ambulation of	6/19/2020. anager and PTA-A's	
	R1's quarterly Min 5/21/20, indicated impairment and re two staff for bed m room and corridor	imum Data Set (MDS), dated R1 had moderate cognitive quired extensive assistance of nobility, transfers, walking in the dressing, and toilet use. The d R1 was not steady, was only		After one month, audits will once weekly. If there are no audits will then be reduced two additional months. Res audits will be reported to the committee each quarter. The Committee will determine we	be reduced to concerns, to randomly for ults of the e QA le QA	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) IDENTIFICATION NUMBER: A. BUILDING		COMI	3) DATE SURVEY COMPLETED C		
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F 689	able to stabilize wit transitions and wall limitation in range on both sides. Also since the previous 2/20/20 due to a significated one fall with injury, and one R1's care plan, last had a performance living (ADL) due to tremors, decreased weakness, and chrextensive assistant and four wheeled wextensive assistant wheeled walker and wheelchair, when a indicated R1 was a falls with injury, decand needed assistant Review of R1's phyorder on 5/1/20 for (PT)/occupational (for ambulation, balance weekly for six identified R1 would sit to stand from reone, improvement	h human assistance during king, and had functional of motion in upper extremities of included, R1 had no falls MDS assessment, completed gnificant change, which with no injury, two or more falls of fall with major injury. It revised 2/25/20, indicated R1 of deficit with activities of daily declining cognition, essential dimobility, generalized onic back pain, and required onic back pain, and required one of two staff, with gait belt walker for transfers, and one of two to three staff, four digait belt, followed by ambulating. The care plan also at risk for falls due to history of clining cognition, and mobility, ance to stabilize.	F 689	deficiency has been correct can cease. All Big Stone F. Therapy Staff demonstrate in transfers and ambulation on 6/2/2020. Review of the be added to the new hire of Stone Therapies physical transfers.	Physical ed competency n of residents e new policy will hecklist for Big	

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able to stand without at least 30 seconds would be able to an CGA (contact guaraneeds to have one to help steady body minimal assist with anterior weight shift. Review of the Physe Encounter Note(s), "Once standing [R1 with only CGA for sindicated, all activitiat all times to avoid most difficulty with in backwards direct to avoid loss of bala Treatment Encountincluded R1 reporte today," and staff reduring a transfer afthree staff to keep Therapy Treatment 5/18/20, included, For sets," on parallel bate [physical therapy as pt [patient]; pt sustate to switch position to included, "During signal backward when switch positions with [hand hold assist] or gait belt and until the with pt."	ut upper extremity support for a without loss of balance, and inbulate at least 200 feet with dissist-physical therapist or two hands on patients body or help with balance) to rolling walker and cues for it less than 25% of time. Sical Therapy Treatment dated 5/14/20, indicated, it is able to maintain balance several minutes." Also ies with CGA to minimal assist it loss of balance, and R1 had retrobalance (loss of balance tion) requiring minimal assist ance. Physical Therapy ter Note(s), dated 5/15/19, and his legs were "really sore ported R1's "knees buckled" iter PT on 5/14/20, and it took R1 from falling. Physical tencounter Note(s), dated R1 completed "standing glute ars, CGA on gait belt. "PTA sesistant] positioned in front of ains falls when PTA steps back of side of patient." Also tanding glute sets pt sustains a PTA lets go momentarily to the pt having BIL [bilateral] HHA on bars. Patient was wearing a ne fall PTA had been in CGA		889			
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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	PROVIDER OR SUPPLIER ON AREA HEALTH SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 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." 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F 689	indicated he had to R1 stated, "[PTA-A switch sides. I fell to wanted to get strong indicated he wasn't felt himself go back indicated he had a tears in eyes, "[PTA it. It was me. I show Review of the Patie Form, dated 5/18/2 was working with Pfacility rehabilitation him holding the gain each side of the pastepped back as shoosition to stand at balance backwards PTA-A let go of the Review of the Apple documentation, data results indicated Refracture of right fibroof the lower leg) and right humeral neck that extends from sand CT (computeric brain indicated no in (bleeding in head) of the During an interview PTA-A stated she whim having poor bath part of the paster o	wear a boot on his right foot. was walking me and went to back." R1 stated he just ager so he can walk and a sure what happened, he just awards and he hit the floor. R1 gait belt on and stated with A-A] felt bad, but she didn't dould be able to stand." ent Incident/Injury Report and 1:10 p.m. included R1 PTA-A in the parallel bars in the proom, positioned in front of the belt, and R1 was holding onto a rallel bars. PTA-A let go and the was going to change and fell to the floor when a gait belt.	F 6	89		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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F 689	assisted. PTA-A st feet, R1 wanted to pushed into the rehallowed him to rest to help another resstated she assisted him inside the parawas standing in fro having R1 perform stated R1 was in the and she let go of the around to R1's side R1 fell backwards should have had R gait belt, however, prior sessions and parallel bars. PTA-walked with R1 on staggering and unstated, when she as he was not nearly at thought he was impenough for me to wastated, after R1's fand, "Going forwar balance patient, I wasted, or I could have hositions." During an interview physical therapist (worked for a therapist (worked for a therapist fand R1 and R1 in the parameters)	age 5 ated, after approximately 75 sit in the wheelchair. R1 was habilitation room and PTA-A c. RA-A and NA-A left the room ident. After resting, PTA-A d R1 to stand and positioned allel bars. PTA-A stated she int of R1, holding the gait belt, different exercises. PTA-A he middle of the parallel bars, he gait belt momentarily to step e, outside of the parallel bars. to the floor. PTA-A stated she 1 sit prior to letting go of the she had let R1's gait belt go in he had never let go of the A stated the first time she 5/14/20, he was "super steady." On 5/18/20, PTA-A had NA-A and RA-A walked R1, has unsteady. PTA-A stated, "I broving. I felt he was stable walk around him." PTA-A hall, her manager talked to her d, if someone is unsteady or a would have a second person to have him sit first and then or on 5/21/20, at 10:14 a.m. PT) indicated he and PTA-A hay agency, and they were de therapy services to cility. PT stated he oversees ked with her about R1's fall. PT d, by PTA-A's description, that harallel bars, working on hably had him standing in the	F 68	9			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 689	change positions were habilitation room would work with a reindicating he would close, and would he switched positions any re-education for manager that was. When interviewed registered nurse (February when RA-A the floor. When RN room, R1 was lying parallel to the bars elbow and was con and right shoulder. a full body lift, asseprovider was notified emergency room thome, via wheelch RN-A stated R1's beand he required as transferring due to she had only worked but stated, "I know one assist but recesso we were using the tired, depending or During an interview RA-A stated he had upper and lower exthe past five month his lower extremities balance and streng and "time of day," a assist of two staff in a single provider was the past five month his lower extremities and "time of day," a assist of two staff in the sum of the past five worked as the past five month his lower extremities and "time of day," a assist of two staff in the past five worked as the past five month his lower extremities as the past five month his lower extremities and "time of day," a assist of two staff in the past five month his lower extremities as the past	when R1 fell. While in the PT demonstrated how he resident in the parallel bars, It typically have the wheelchair ave the resident sit while he PT stated he had not provided or PTA-A, because she had a responsible for doing that. On 5/21/20, at 10:27 a.m. RN)-A stated she was out in the A came to say that R1 was on II-A got to the rehabilitation gwithin the parallel bars, R1 had a skin tear on the left inplaining of pain in his back R1 was lifted off the floor with essed, and R1's health care ed. R1 was sent to the nat was attached to the nursing air, for further assessment. Sealance "waxes and wanes," sistance of two when his unsteadiness. RN-A stated ed at the facility a short time, they used to transfer him with ently he seemed more unsteady wo. He was more shaky and	F6	689			

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F 689	was always more a afternoon, so that whim. On the day the around 1:00 in the work with PTA-A. FPTA-A and NA-A a the hallway, with Rowheelchair. R1 wal tired, so he was purehabilitation room, therapy normally we stated he left the roresident. When RA rehabilitation room, was complaining of was crying. RA-A ir off the floor with the R1 to the emergency wheelchair. RA-A is staff with transfers, were to let go, he to that everyone knew let him go backwarmany times in those an incident, but I now the work and forth with and do well, and the require physical the had made so much stronger, however, assists because his indicated he had no stated, "She's so go safety. She just got	lert and oriented in the was the best time to work with at R1 fell, RA-A stated it was afternoon, and R1 agreed to R1's gait belt was put on, and ssisted R1 to ambulate into A-A following with a ked part way and became shed by wheelchair into the RA-A stated staff from orked with R1 alone, and RA-A following on the floor, and for any and in the range of	F6	89		

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	I \ /	TE SURVEY MPLETED
		245231	B. WING		05	C / 22/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 30 S BEHL ST APPLETON, MN 56208		12212020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	During an interview RN-B stated, after humerus in Decemsome strength backwell, however, R1's and required two a transfers. RN-B indicate the past due to sel PTA-A was workin fall occurred. Whe after the fall, RN-B had been gaining sconfident in his prolet go of him briefl stated she told PT always used two attransfers. RN-B stated she told PT always used two attransfers. RN-B stated she was the PTA-A or therapy in When interviewed stated she was the Therapies, and wa PTA-B stated a PT week and overseed received a phone of after R1 fell. PTA-A parallel bars, work was in front of R1. of R1's way, and the on the floor. PTA-E	v on 5/21/20, at 1:37 p.m. a fall with fracture to his left aber, R1 had really gained ck, and as of late, was doing s strength had been "variable," ssist for ambulation and dicated R1 had several falls in f transferring. RN-B stated g with R1, by herself, when the n completing the investigation indicated PTA-A reported R1 strength and PTA-A was so ogress that she felt she could y to switch positions. RN-B A-A that the nursing assistants esists for ambulation and ated there were never safety A-A worked with residents, and een any prior incidents with	F 68	9		
	"We talked about t should have done differentlyhaving	this balance." PTA-B stated, he situation and what she or could have done him sit, move wheelchair teone assist." PTA-B stated,				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED C
		245231	B. WING _		05	/22/2020
	PROVIDER OR SUPPLIER ON AREA HEALTH			STREET ADDRESS, CITY, STATE, ZIP C 30 S BEHL ST APPLETON, MN 56208		· · - ·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	"We don't typically therapy, and with C exposure down. The patients by themse expectation would the patient that we' During a follow up a.m. PT stated, "We fall risk and posteric have contact guard guard assist means patient while walking period of time when based on judgeme testing it and being patient We are try when we have our gives them a false he and PTA-A discrime. PT-A stated, had her hand on [For to that decision. It's at what she does." Review of the facilia Plan, dated 7/19, in be used in develop routines and will be who have responsing services to the residence in the facilia Risk-Managing, da previous evaluation will identify interver specific risks and control of the facilia review of the facilia r	have two staff to assist with COVID, we're trying to keep the perapists are treating all elves." PTA-B stated, "My be, that in the future, to look at re treating." interview on 5/22/20, at 10:40 hen in parallel bars, with [R1's] for loss of balance, [R1] should diassist," and stated, "Contact is having your hand on the ing." PT stated, "There comes a re less support is needed, intI make that judgement by it right there to catch the ving to progress the patient and hands on them all the time, it sense of security." PT stated eluss patients' status all the "I do believe she should have lead up is unfortunate, she's very good ty's policy, Using the Care included, "The care plan shall be available to staff personnel bility for providing care or ident." ty's policy, Falls and Fall ted 7/19, included, "Based on its and current data, the staff intions related to the resident's causes to try to prevent the grand to try to minimize	F 68			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		FIPLE CONSTRUCTION NG	((X3) DATE SURVEY COMPLETED	
		245231	B. WING			C 05/22/2020	
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	00.11.1010	
APPLETO	ON AREA HEALTH			30 S BEHL ST APPLETON, MN 56208			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO			



Protecting, Maintaining and Improving the Health of All Minnesotans

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 <u>only a suggestion</u> 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

Appleton Area Health June 5, 2020 Page 2

"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,

Towards Stapson

Douglas Larson, Enforcement Specialist Minnesota Department of Health Appleton Area Health June 5, 2020 Page 3

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

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B WINC			
		00655	B. WING		05/2	2/2020
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
APPLET	ON AREA HEALTH	30 S BEH APPLETC	LSI ON, MN 5620	98		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall I	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of I lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. It is several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
		, surveyor of this visited the above provider for vey complaint investigation to				
		ction orders are issued. r electronic plan of correction				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

06/15/20 **Electronically Signed**

TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			SURVEY PLETED	
		00655	B. WING		1	2 2/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	•	
APPLET	ON AREA HEALTH	30 S BEH APPLETO	L ST ON, MN 5620	08		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	ранина в помера	wed these order, and identify	2 000			
2 830	MN Rule 4658.0520 Proper Nursing Care Subpart 1. Care in receive nursing care custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the resident must remain prefers to remain in This MN Requirements. This MN Requirements by: Based on observation review, the facility facili	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident abed. ent is not met as evidenced on, interview, and document ailed to implement adequate fety measures to ensure from accident hazards, for 1 reviewed. This resulted in R1 sustained a fall resulting in	2 830	Acknowledged. See tag F689 plar correction.	n of	6/15/20
	R1's admission rec R1 had diagnoses i pain, dorsalgia (stin of pain in back or s vertigo (sensation of	ord, dated 5/2/18, indicated ncluding dementia, chronic aging or burning like sensation pine that radiates), tremors, of feeling off balance), and rthritis (degeneration of joint				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00655	B. WING			C 2 2/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
APPLE	TON AREA HEALTH	30 S BEH APPLETO	L ST DN, MN 5620	8		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 830	cartilage and the unitarity of the previous I cartilage and the unitarity of the previous I cartegorized as, "High R1's Safety Risk Assindicated R1 had a gait, chronic/acute of dizziness, balance leg movement, and Also included, R1 whistory of falls and of mobility, and was not ambulate on own. R1's quarterly Mining 5/21/20, indicated Fimpairment and requive staff for bed moreom and corridor, MDS also identified able to stabilize with transitions and walk limitation in range of on both sides. Also since the previous I 2/20/20 due to a significated one fall which with injury, and one R1's care plan, last had a performance living (ADL) due to tremors, decreased weakness, and chroextensive assistance was a sistance and control of the previous	nderlying bone). ale, completed 5/7/20, story of falling, had impaired or forgets limits, and was	2 830			

Minnesota Department of Health

STATE FORM 5899 5UQI11 If continuation sheet 3 of 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00655	B. WING		05/2	2 2/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
APPLET	ON AREA HEALTH	30 S BEH	_			
	I		N, MN 5620	18		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 3	2 830			
2 830	wheeled walker and wheelchair, when a indicated R1 was at falls with injury, dec and needed assistated Review of R1's physorder on 5/1/20 for (PT)/occupational (for ambulation, balan R1's Physical Thera Treatment, dated 5 generalized muscle treatment approach exercises, neuromustherapy evaluation, twice weekly for six identified R1 would sit to stand from recone, improvement i strength in order to able to stand without at least 30 seconds would be able to an CGA (contact guard needs to have one to help steady body minimal assist with anterior weight shift Review of the Phys Encounter Note(s), "Once standing [R1 with only CGA for sindicated, all activiti	I gait belt, followed by mbulating. The care plan also trisk for falls due to history of lining cognition, and mobility, ince to stabilize.	2 830			
	in backwards direct	retrobalance (loss of balance ion) requiring minimal assist ance. Physical Therapy				

Minnesota Department of Health

STATE FORM 5899 5UQI11 If continuation sheet 4 of 11

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00655	B. WING		05/2	2/2020
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
APPLET	ON AREA HEALTH	30 S BEH	L ST N, MN 5620	8		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Treatment Encount included R1 reported today," and staff reduring a transfer aff three staff to keep I Therapy Treatment 5/18/20, included, Fests," on parallel bases," on parallel bases, on parallel base	ge 4 er Note(s), dated 5/15/19, ed his legs were "really sore corted R1's "knees buckled" ter PT on 5/14/20, and it took R1 from falling. Physical Encounter Note(s), dated R1 completed "standing glute ers, CGA on gait belt. "PTA esistant] positioned in front of eins falls when PTA steps back of side of patient." Also eanding glute sets pt sustains PTA lets go momentarily to h pt having BIL [bilateral] HHA en bars. Patient was wearing a fine fall PTA had been in CGA fino on 5/21/20, at 2:00 p.m. bed, resting. A sling was arm/shoulder, and R1 wear a boot on his right foot. I was walking me and went to eack." R1 stated he just ger so he can walk and sure what happened, he just ewards and he hit the floor. R1 gait belt on and stated with A-A] felt bad, but she didn't do eld be able to stand." ent Incident/Injury Report 0, at 1:10 p.m. included R1 TA-A in the parallel bars in the n room, positioned in front of to belt, and R1 was holding onto rallel bars. PTA-A let go and the was going to change R1's side. R1 had loss of to and fell to the floor when	2 830			

Minnesota Department of Health

STATE FORM 5099 5UQI11 If continuation sheet 5 of 11

iviinneso	ita Department of He	eaith				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		CONFEELED	
		00655	B. WING		05/2	2/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
A DDI ET	ON ADEA HEALTH	30 S BEH	L ST			
APPLET	ON AREA HEALTH	APPLETO	N, MN 5620	98		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETE DATE
				DEFICIENCY)		
2 830	Continued From pa	ge 5	2 830			
	PTA-A let go of the	gait belt.				
	Review of the Apple	eton Area Health				
		ed 5/18/20, included X-ray				
		1 sustained a nondisplaced				
		la (long, thin and lateral bone				
		d nondisplaced fracture of (long bone of the upper arm				
		houlder to elbow) when he fell,				
		zed tomography) scan of the				
		ntracranial hemorrhage				
	(bleeding in head) of	or craniai iractures.				
		on 5/21/20, at 9:55 a.m.				
		vas working with R1 due to				
		lance and history of falls. /18/20, she ambulated with R1				
		the hallway. R1 wore a gait				
	belt, used a four wh	neeled walker, and nursing				
		nd restorative aide (RA)-A				
		ated, after approximately 75 sit in the wheelchair. R1 was				
	*	abilitation room and PTA-A				
		. RA-A and NA-A left the room				
		dent. After resting, PTA-A				
		R1 to stand and positioned llel bars. PTA-A stated she				
		nt of R1, holding the gait belt,				
	having R1 perform	different exercises. PTA-A				
		e middle of the parallel bars,				
		e gait belt momentarily to step e, outside of the parallel bars.				
		o the floor. PTA-A stated she				
		1 sit prior to letting go of the				
		she had let R1's gait belt go in				
	•	he had never let go of the				
	•	A stated the first time she				
		5/14/20, he was "super teady." On 5/18/20, PTA-A				
		nd NA-A and RA-A walked R1,				

Minnesota Department of Health

STATE FORM 5009 5UQI11 If continuation sheet 6 of 11

STATEMENT OF DEFICIEN		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE		
AND PLAN OF CORRECTION	JN	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	COMPLETED	
		00655	B. WING		I	C 2 2/2020	
NAME OF PROVIDER OR	SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
APPLETON AREA HE	ALTH	30 S BEH APPLETO	LST ON, MN 5620	08			
PREFIX (EACH D	EFICIENC'	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
thought he enough for stated, after and, "Going balance par steady, or switch possible provider was a practiced residents a she had R' balance, and stated he a she had R' balance, and change por rehabilitation would work indicating he close, and switched practiced practiced practiced providents and registered hallway where the floor. We room, R1 we parallel to the elbow and and right si a full body provider was emergency	inearly a was imported to me to was imported to me to was interviewed a theraped then was itions. In the period then was itions would have a the period then would have a the period then would have a the period to proviewed the would have a the period then would have a the period then RA-A was lying the bars. If was conhoulder, asset as notified to room the period to the period the p	age 6 as unsteady. PTA-A stated, "I proving. I felt he was stable valk around him." PTA-A all, her manager talked to her d, if someone is unsteady or a would have a second person to ave him sit first and then on 5/21/20, at 10:14 a.m. PT) indicated he and PTA-A by agency, and they were de therapy services to illity. PT stated he oversees ked with her about R1's fall. PT, by PTA-A's description, that barallel bars, working on ably had him standing in the ent out of the parallel bars to when R1 fell. While in the PT demonstrated how he resident in the parallel bars, typically have the wheelchair ave the resident sit while he PT stated he had not provided or PTA-A, because she had a responsible for doing that. On 5/21/20, at 10:27 a.m. EN)-A stated she was out in the acame to say that R1 was on l-A got to the rehabilitation within the parallel bars, R1 had a skin tear on the left aplaining of pain in his back R1 was lifted off the floor with ssed, and R1's health care ed. R1 was sent to the nat was attached to the nursing air, for further assessment.	2 830				

Minnesota Department of Health

STATE FORM 5009 5UQI11 If continuation sheet 7 of 11

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		D WING				
		00655	B. WING		05/2	2/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ADDI ET	ON ADEA HEALTH	30 S BEHI	LST			
APPLET	ON AREA HEALTH	APPLETO	N, MN 5620	8		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ae 7	2 830			
2 830	RN-A stated R1's be and he required asstransferring due to she had only worked but stated, "I know one assist but recesso we were using to tired, depending on During an interview RA-A stated he had upper and lower exthe past five month his lower extremities balance and streng and "time of day," a assist of two staff in to being more weak was always more a afternoon, so that whim. On the day the around 1:00 in the awork with PTA-A. RPTA-A and NA-A as the hallway, with RA wheelchair. R1 wall tired, so he was purehabilitation room. therapy normally we stated he left the roresident. When RA rehabilitation room, was complaining of was crying. RA-A in off the floor with the R1 to the emergence	alance "waxes and wanes," sistance of two when his unsteadiness. RN-A stated at the facility a short time, they used to transfer him with only he seemed more unsteady wo. He was more shaky and the time of day." I on 5/21/20, at 10:39 a.m. It been working with R1 for tremity strengthening, and in s, R1 had gained strength in s, however, RA-A stated his th still "depended on the day," and stated R1 always required a the morning with cares due at and groggy. RA-A stated R1 lert and oriented in the was the best time to work with at R1 fell, RA-A stated it was afternoon, and R1 agreed to R1's gait belt was put on, and sisted R1 to ambulate into RA-A following with a ked part way and became shed by wheelchair into the RA-A stated staff from orked with R1 alone, and RA-A om to assist with another rA walked back by the R1 was lying on the floor, and pain in his right shoulder and adicated he assisted to lift R1 e full body lift and transported by department in his	2 830			
	staff with transfers. were to let go, he to	tated, "We always have two He is that unsteady. If we ends to go back. I assumed that. The main thing is don't				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
			A. BUILDING.		С	
		00655	B. WING			2/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
APPLET	ON AREA HEALTH	30 S BEHI APPLETO	LST N, MN 5620	8		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	many times in those an incident, but I not an incident and well, and the require physical the had made so much stronger, however, assists because his indicated he had not stated, "She's so go safety. She just got feeling that he could could switch position." During an interview RN-B stated, after a humerus in Decem some strength backwell, however, R1's and required two as transfers. RN-B ind the past due to self PTA-A was working fall occurred. When after the fall, RN-B had been gaining sconfident in his project go of him briefly stated she told PTA always used two as transfers. RN-B state concerns when PTA	dsI have worked with him e parallel bars and never had ever let go." on 5/21/20, at 1:30 p.m. (DON) stated R1 had "gone in therapy, would get stronger en would become ill and would erapy again. DON stated R1 progress and was getting "We continued to use two is strength is so variable." DON in concerns with PTA-A and indo. She's so concerned with it too comfortable maybe, ind hold the bars briefly so she ins." on 5/21/20, at 1:37 p.m. in fall with fracture to his left ber, R1 had really gained in, and as of late, was doing is strength had been "variable," esist for ambulation and icated R1 had several falls in it transferring. RN-B stated in with R1, by herself, when the in completing the investigation indicated PTA-A reported R1 it rength and PTA-A was so gress that she felt she could into switch positions. RN-B in A-A that the nursing assistants is issists for ambulation and ited there were never safety in A-A worked with residents, and iten any prior incidents with	2 830			
	When interviewed of	on 5/21/20, at 6:01 p.m. PTA-B				

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STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00655	B. WING		C 05/22/2020			
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE				
ADDI ET	ON AREA HEALTH	30 S BEHI	LST					
APPLET	ON AREA HEALTH	APPLETO	N, MN 5620	8				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE		
2 830	Continued From pa	ge 9	2 830					
2 630	stated she was the Therapies, and was PTA-B stated a PT week and oversees received a phone ca after R1 fell. PTA-A parallel bars, working was in front of R1. For fR1's way, and the on the floor. PTA-B R1 a few months aga tendency to lose to "We talked about the should have done of differentlyhaving for closer, having some "We don't typically therapy, and with C exposure down. The patients by themsel expectation would be the patient that we're the patient that we're patient while walking period of time where based on judgement testing it and being patientWe are trywhen we have our for gives them a false she and PTA-A discutime. PT-A stated, "had her hand on [R	clinic manager for Big Stone is PTA-A's manager/supervisor. is at the facility three days a septa-A. PTA-B stated she all from PTA-A immediately a reported R1 was in the ing on some things, and PTA-A PTA-A was going to move out enext thing she knew, R1 was stated she had worked with go, and stated, "He does have this balance." PTA-B stated, in esituation and what she is could have done thim sit, move wheelchair eeone assist." PTA-B stated, have two staff to assist with eOVID, we're trying to keep the erapists are treating all lives." PTA-B stated, "My be, that in the future, to look at	2 630					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00655	B. WING		I	C 22/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	, ,	STATE, ZIP CODE		
APPLET	ON AREA HEALTH		N, MN 5620	8		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 10	2 830			
	Plan, dated 7/19, in be used in developi routines and will be who have responsit services to the residence of the facilit Risk-Managing, dat previous evaluation will identify interven specific risks and care	cy's policy, Falls and Fall red 7/19, included, "Based on s and current data, the staff tions related to the resident's auses to try to prevent the g and to try to minimize				
	The director of The review/revise policie fall precautions and assessed as high ri re-educate staff on A system for evalua implementation of the developed, with the brought to the facility Committee for review	THOD OF CORRECTION: rapy or designee, could es and procedures related to I when working with patients sk for falling. They could the policies and procedures. ating and monitoring consistent hese policies could be results of these audits being ty's Quality Assurance ew. R CORRECTION: Fourteen				

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