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	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Appleton Area Health	30 S Behl St Appleton, MN 56208

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, interview, and record review the facility failed to immediately report (within two hours) an incident of neglect (elopement) to the State Agency (SA) for 1 of 3 residents (R1) when R1 was able to leave the building unsupervised. Findings include:Facility Incident Report dated 1/11/26, indicated R1 had gone to the dining room and staff reported R1 had made it out of the building through the south exit door by the dining room. Wander guard alarm did not go off and R1 was found to be about 15 feet out the door. R1 had two sweaters on, shoes and bag. Staff spent time attempting to calm and redirect R1 when outside. R1 later agreed to come back into the facility on the condition she would be allowed to talk to the doctor. R1 was assisted back to the facility safely. Facility report to SA was on 1/11/26 at 2:40 p.m. Camera footage reviewed on 1/22/26 indicated on 1/11/26 at 9:17 a.m., R1 was in her wheelchair self-propelling toward dining room door which led outside. Two other residents were present in dining room, and one staff member came into the dining room and escorted another resident out of the dining room. R1 pushed the door open with her hands and continued to go outside and remained on facility property at 9:17 a.m. Staff was observed joining R1 outside at 9:19 a.m. R1 returned in the facility with staff at 9:29 a.m.During interview on 1/23/26 at 12:24 p.m., director of nursing (DON) stated she had not made the report to the SA within 2 hours because there was no harm to R1. DON stated she had reviewed their policy and understood reporting neglect when there was no harm the time frame was 24 hours. DON agreed the policy and regulations were not followed.Facility policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property revision date 3/18/25 indicated the facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involved abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials.

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.

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

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NAME OF PROVIDER OR SUPPLIER Appleton Area Health		STREET ADDRESS, CITY, STATE, ZIP CODE 30 S Behl St Appleton, MN 56208	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure care plan interventions were revised and implemented as needed for 1 of 3 residents (R1) who was at risk of elopement and was demonstrating consistent behavior for elopement.Findings include:R1's admission Record indicated R1 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, unspecified dementia with other behavioral disturbances.R1's annual Minimum Data Set (MDS) dated [DATE], identified moderate cognitive impairment and a wander/elopement alarm was used daily.R1's care plan dated 11/13/25 indicated R1 had impaired thought processes related to vascular dementia and history of cerebral infarction, potential wandering and exit seeking to go home. Interventions included cue, reorient and supervise as needed, keep R1's routine consistent and try to provide consistent care givers as much as possible, wander guard on wheelchair related to comments about leaving and wanting to go home. The care plan section related to elopement and safety, lacked evidence of the interventions directed here.R1's care plan dated 1/11/26 indicated R1 was an elopement risk related to history of attempts to leave facility unattended, impaired safety awareness, disease process (dementia), memory impairment. Interventions included distracting R1 with pleasant diversions, structured activities, food, conversation, television, and books. Despite significant history of wandering behavior, not additional interventions were added to R1's care plan, even when she had packed a suitcase with the intention to go home. Revisions were started on 1/22/26 but not completed to keep R1 safe from elopement. R1's Wandering Risk Scale dated 10/23/25, indicated R1 had recent history of packing items in a suitcase intending to go home, difficult to redirect. R1 had history of wanting to go to granddaughters. Wander guard in place on wheelchair.R1's facility Progress notes indicated on 1/11/26, R1 was agitated and reported to staff wanting to go home and packed her belongings. R1 managed to open the door and stepped outside onto the snow. Staff were able to redirect R1 back inside the facility. Wander guard was changed the day before, functioning normally with alarms going off when near a door. (wander guard did not activate)R1's medical record lacked evidence care planned interventions were implemented to redirect, reorient, or increase supervision prior to the elopement event despite clear signs of elopement behavior. During interview on 1/22/26 at 2:07 p.m., MDS Registered Nurse (RN)-A stated her role was complete MDS, care plans and nursing assessments. RN-A stated after R1's elopement the inter-disciplinary team (IDT) team met and another wander assessment was completed and it had changed a little bit, and R1 was now a high risk wanderer; the care plan was reviewed and no changes were needed however during interview RN-A reviewed R1's care plan and identified the care plan was not complete and specific interventions should have been added.During interview on 1/23/26 at 11:49 a.m., social worker (SW) stated the IDT team met after R1 had eloped; R1's care plan was reviewed and was not found to need revisions. SW stated staff are to distract R1 when agitated with food, activities and provided one to one by staff when available. SW stated R1 was an avid reader, however only had a couple of books in her room, R1 also was a hoarder and the facility wanted to keep her room as minimal to avoid safety concerns. SW stated she had not worked with the family recently to develop a more personalized care plan and agree this could be beneficial for R1 and her agitation.Facility policy titled Care Plans-Comprehensive Person-Centered Policy revision date 12/29/23 indicated the IDT, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to supervise 1 of 3 residents (R1) at risk for elopement when R1 was able to leave the facility without staff knowledge despite while wearing a wander guard pendent, which was not placed according to Manufacturers Guidelines and did not alert staff. Findings include:R1's admission Record indicated R1 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, unspecified dementia with other behavioral disturbances.R1's annual Minimum Data Set (MDS) dated [DATE], identified moderate cognitive impairment and a wander/elopement alarm was used daily.R1's care plan dated 1/11/26 indicated R1 was an elopement risk related to history of attempts to leave facility unattended, impaired safety awareness, disease process (dementia), memory impairment. Interventions included distracting R1 with pleasant diversions, structured activities, food, conversation, television, and books. Document wandering behaviors and attempted diversional interventions in behavior log.R1's care plan dated 11/13/25 indicated R1 had impaired thought processes related to vascular dementia and history of cerebral infarction, potential wandering and exit seeking to go home. Interventions included cue, reorient and supervise as needed, keep R1's routine consistent and try to provide consistent care givers as much as possible, wander guard on wheelchair related to comments about leaving and wanting to go home.R1's Wandering Risk Scale dated 10/23/25, indicated R1 had recent history of packing items in a suitcase intending to go home, difficult to redirect. R1 had history of wanting to go to granddaughters. Wander guard in place on wheelchair.R1's facility progress notes indicated on 1/11/26, R1 was agitated and reported to staff wanting to go home and packed her belongings. R1 managed to open the door and step outside to the snow. Staff were able to redirect and bring the resident back inside. Wander guard was changed the day before, functioning normally with alarms going off when near a door.Observation on 1/22/26 at 10:32 a.m., R1's wander guard was under the seat of the wheelchair hanging from a metal piece and secured by the wrist band closure.Camera footage reviewed on 1/22/26 indicated on 1/11/26 at 9:17 a.m., R1 was in her wheelchair self-propelling toward dining room door which led outside. Two other residents were present in dining room, and one staff came into the dining room and escorted another resident out of the dining room. R1 pushed the door open with her hands and continued to go outside but remained on campus at 9:17 a.m. Staff was observed outside at 9:19 a.m. with R1 and she returned to the facility with staff at 9:29 a.m.Facility Incident Report dated 1/11/26, indicated R1 had gone to the dining room and staff reported R1 had made it out of the building through the south exit door by the dining room. Wander guard alarm did not go off and R1 was found to be about 15 feet out the door. R1 had two sweaters on, shoes and bag. Staff spent time attempting to calm and redirect R1 when outside. R1 later agreed to come back into the facility on the condition she will be allowed to talk to the doctor. R1 was assisted back to the facility safely, R1 refused vitals and nursing assessment. R1 talked with a doctor and was upset with the doctor as they would not give discharge orders. Doctor did give an order for haloperidol 5 milligrams for behavior management, and it was effective. No further behaviors noted. Maintenance was notified of south door exit alarm and was fixed by replacing the battery to the transmitter. R1 wander guard was checked and was functioning as expected. Call placed to wander guard manufacturer, Securitas, and requested to have a technician assess at the facility. On 1/12/26 director of nursing (DON) confirmed all wander guards in working conditions. On 1/15/26 DON updated Unsafe Resident Policy and Elopement Policies and updated to have the day nurse check all wander guard doors and use a pendent to ensure alarm doors sound and are operational. Daily check log sheets updated and placed in binder at nurses' station with manual for the wander (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	guard.Securitas assessment, wander guard manufacturer, was completed on 1/20/26 and assessment indicated the wander guard system was operational.[NAME] Healthcare wander guard blue manual published 7/16/17 indicated the strap of the wander guard was to be worn on the individual's wrist or ankle. During interview on 1/22/26 at 10:55 a.m. R1 stated she tried to leave the facility, but they would not let her go and left the facility through the dining room. R1 stated she was not aware of an alarm sounding when leaving the facility. R1 recalled she had a wander guard on her wheelchair.During phone call interview on 1/22/26 at 1:30 p.m., [NAME] Healthcare Wander Guard representative stated the pendent was to be worn on the wrist or ankle and if pendent was placed on metal it would not be as effective and could malfunction.During interview on 1/22/26 at 2:07 p.m., RN-A stated she completed all the MDS, care and nursing assessments. RN-A nurse stated after R1's elopement the care plan was reviewed, and no changes were needed however there was no mention of the pendent location on R1's wheelchair and if that was a factor in the pendant not alarming. R1 did not wear the pendant on her wrist or ankle. RN-A stated she had not reviewed the wander guard manual or called the company to verify placement of the pendant would continue to operate safely if placed in other locations.During interview on 1/22/26 at 3:15 p.m., maintenance staff (MS) stated when R1 eloped he came to the facility and assessed the system, transmitter battery was changed, and system was working again. MS stated the wander guard company came a few days later and found no issues with the system.During phone call interview on 1/22/26 at 3:41 p.m., director of nursing (DON) stated she was notified of R1's elopement via phone call from staff and we put a plan together to protect the residents especially with those that had wander guards which included maintenance to assess function of the system, which found a new battery was needed. DON stated the Wandering policy and wander guard manual was reviewed and found wander guards were to be tested daily and that was changed in our practice and policy. DON stated she had called the wander guard company to inform them of the elopement and asked for an updated manual. DON stated the root cause finding was the transmitter battery was dead or low. DON stated she was not aware why R1's wander guard pendant was under the wheelchair seat and was not aware the pendant was to be on an individual's wrist or ankle as she had to not reviewed that section of the manufacturers guide. Facility policy titled Wandering-Unsafe Resident, revised date 1/15/26, indicated if it is determined by IDT that a resident is in need of a wandering signaling device, and an order is obtained from practitioner, a wander guard bracelet will be placed on either the resident's wrist or ankle. If resident is confined to a wheelchair, wander guard pendant may be placed on resident's wheelchair. Facility will follow manufacturer's guidelines for wander guard activation and use.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review facility failed to develop mental health strategies for 1of 3 resident (R1) who experience agitation related to a desire to go home. Findings include:R1's admission Record indicated R1 was admitted to the facility on [DATE]. Diagnoses included cerebral infarction, unspecified dementia with other behavioral disturbances.R1's annual Minimum Data Set (MDS) dated [DATE], identified moderate cognitive impairment and a wander/elopement alarm was used daily.R1's care plan dated 1/11/26 indicated R1 was an elopement risk related to history of attempts to leave facility unattended, impaired safety awareness, disease process (dementia), memory impairment. Interventions included distracting R1 with pleasant diversions, structured activities, food, conversation, television, and books. Document wandering behaviors and attempted diversional interventions in behavior log.R1's care plan dated 11/13/25 indicated R1 had impaired thought processes related to vascular dementia and history of cerebral infarction, potential wandering and exit seeking to go home. Interventions included cue, reorient and supervise as needed, keep R1's routine consistent and try to provide consistent care givers as much as possible, wander guard on wheelchair related to comments about leaving and wanting to go home. R1's care plan dated 1/27/25, indicated R1 had a behavior problem of hoarding items and food, yell/scream, verbally abusive, twisting staff wording and situations, fabricating stories, and rejection of care. Interventions included administer medications as ordered, anticipate and meet R1's needs, assist R1 to develop more appropriate methods of coping and interacting. Encourage R1 to express feelings appropriately. R1 gets defensive when discussing abundance of items and clutter in room; family reports a historic issue her whole life. If reasonable, discuss her behavior, Explain/reinforce why behavior is inappropriate for R1's health and safety. Care plan lacked evidence on how the staff were to engage R1 when she was anxious, what methods of coping were successful for R1, activities to engage R1 with and what level of supervision would be necessary to keep her safe.Observations of R1's private room on 1/22/26, spacious with bed, closet, television, private bathroom, and dresser. R1 had limited personal belongings in room such as books, pictures, or other forms of activities.During interview on 1/22/26 at 10:55 a.m., R1 stated she wanted to return home and be with her belongings and did not need the care from the facility. R1 stated she had love to read and enjoyed doing activities, however her room had nothing to do in it.During interview on 1/22/26 at 2:07 p.m., MDS registered nurse (RN-A) stated R1's care plan revisions had not been completed since the elopement incident, and she was not aware of staff using different interventions when R1 was agitated then what was in the care plan. RN-A stated R1 does attend activities which can be helpful when she is agitated, and staff try their best to keep R1 safe.During interview on 1/23/26 at 10:38 a.m., licensed practical nurse (LPN)-A stated when R1 was agitated she would show pictures of babies and ask her about when she was a mom, this distraction was not always effective and R1 was very unpredictable. RN-A stated this specific intervention was not on R1's care plan and recalled R1 did not have a lot of personal items in her room which could help her feel more at home.During interview on 1/23/26 at 11:49 a.m., social worker (SW) stated she developed the behavioral part of the care plan and did not find it needed to be revised. SW stated staff are to distract R1 when agitated with food, activities and one to one by staff, there was nothing more we could personalize her care plan with. SW stated R1 was an avid reader, however there were only had a couple of books in her room, she was also a hoarder and the facility wanted to keep her room as minimal as possible to avoid safety concerns. SW stated she had not worked with the family to develop updated personalized care plan to explore providing R1 with more items from her home and things R1 enjoyed doing. SW agreed (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	these additional things could help with R1 agitation to have things around her she knows, enjoys and care about.Facility policy titled Care Plan Comprehensive Person Centered Policy revised date 12/29/23, indicated care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making: when possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers. Care planning individual symptoms in isolation may have little, if any, benefit for the resident.