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	01/29/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 49336 Based on interview and document review, the facility failed to ensure 1 of 5 residents (R32) was reassessed for as needed (PRN) anti-anxiety medication (diazepam) every 14 days to ensure the appropriateness of continued use. Findings include: R32's 10/8/24, Significant Change Minimum Data Set (MDS) identified R32 had a diagnoses of Alzheimer's and dementia with agitation. R32 was cognitively impaired and was administered antipsychotic, antianxiety and antidepressant medication daily. R32's diazepam was ordered on 11/8/24 and started the same day, however, there was no indication the physician (MD) had limited the order for 14 days to ensure it was reviewed for continuation. R32's December 2024, Medication Administration Record (MAR) identified diazepam 5 milligram (mg) was to be given by mouth every 8 hours as needed for agitation, physical aggression, and restlessness beginning 11/08/24. The MAR lacked documentation of an end date. R32's Progress note identified on: 1) 11/26/24, the physician ordered PRN diazepam and was to be reviewed in 14 days. 2) 11/26/24, the pharmacist's (RPh) recommendation identified staff were to monitor R32's behaviors. The pharmacist identified the physician (MD) reviewed the diazepam and the order was extended to 14 days. 3) 12/10/24, the nurse practitioner (NP) reviewed R32's diazepam. R32's behaviors had improved with medication management and the NP extended the diazepam 14 days. 4) 12/28/24, the RPh recommendation identified R32's diazepam was reviewed. They had no recommendations. There was no mention the RPh had identified the MD reviewed the diazepam within 14 days by 12/24/24. (continued on next page)

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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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R32's December 2024, Treatment Administration Record (TAR) identified a reminder for staff to notify the MD to review the diazepam prior to the end of the 14 days to justify the continuation of the need for the medication. Review of the printed December 2024, TAR given to the MD on 1/15/25 identified staff wrote FYI: Nursing orders require notification of use of R32's diazepam in the last 14 days. There was no indication staff had notified the MD prior to 1/15/25 to review the diazepam and justify the continued use and place a new order. R32's current, undated care plan identified R32 had taken diazepam for anxiety. Staff were to administer anti-anxiety medications and monitor for the effectiveness of the medication and report adverse reactions and side effects such as memory loss, slurred speech, confusion, or nausea. Staff were to monitor and record target behaviors and inappropriate responses to verbal communication and violence and/or aggression towards staff or others. There was no mention staff were to notify the MD to review the diazepam at 14 days to continue the medication. During interview and TAR review on 1/29/25 at 10:09 a.m., with licensed nurse (LPN)-A identified R32's TAR provided reminders for the nursing staff to notify the MD to review the diazepam every 14 days. LPN-A agreed there was documentation to support the provider was contacted on 12/24/24. Interview on 1/29/25 at 10:10 a.m., with LPN-B identified she agreed R32's PRN order should have been reviewed by the provider every 14 days. Interview on 1/29/25 at 11:41 a.m., with medical director identified staff should have notified the MD for R32 by day 14 to have the MD review the diazepam and document the rational to continue the order. Interview on 1/29/25 1:29 p.m., with director of nursing (DON) identified her expectation was for to staff notify the MD of the absence of a stop date on limited 14-day psychotropic medications and notify the MD if re-evaluation of the medication needed to occur for continuation. Review of October 2019, Psychotropic Medication Usage policy indicated the facility was to monitor residents receiving psychotropic medications to evaluate their effectiveness. In addition, the facility was to ensure a process for reviewing the continued need for psychotropic medications. There was no mention how the facility ensure duration of psychotropic medication use was enforced.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34083 Based on interview and document review the facility failed to have a current, ongoing system of surveillance to identify potential outbreaks of infectious disease, ensure transmission-based precautions (TBP) were implemented timely, perform root cause analysis with contact tracking to identify patterns of illness in staff or residents, and prohibit staff from returning to work prematurely following identified symptoms. This had the potential to affect all 33 residents in the facility. In addition, the facility failed to ensure 1 of 1 whirlpool tub was appropriately disinfected between resident use according to the manufacturer's directions. This had the potential to affect 10 of 32 residents who used the whirlpool tub. Findings include: SURVEILLANCE RESIDENTS Review of the December 2024, resident infection control log identified the facility experienced a COVID-19 outbreak between (December 15, 2024, through January 20, 2025). 17 of 32 residents were identified as testing positive for COVID-19 between December 15, through 31, 2024, (R1, R2, R7, R10, R13, R14, R15, R18, R19, R23, R24, R25, R32, R33, R86, R87, and R88). Review of the January 2025, infection control surveillance log identified one resident tested positive (R27). The resident surveillance logs above identified the resident name, room number, date tested positive, and off isolation date. The log failed to identify the date and type of TBP and when the precautions were implemented. STAFF Review of the staff infection control log for November 2024 identified call-ins for illness as follows: 1)Registered nurse (RN)-A reported vomiting on 11/11/24 with no additional follow up or notation of when she returned to work. She then also reported headache, fever, cough, sore throat and body aches on 11/24/24 and tested positive for COVID. 2) Nursing assistant (NA)-A reported vomiting, nausea, cough on 11/11/24. 3) Unidentified staff person-reported illness on 11/12/24 with no S/S identified. 4) Licensed practical nurse (LPN)-C -reported a sore throat on 11/18/24 with no additional S/S identified. 5) NA-B- reported illness with vomiting on 11/20/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6) NA-C- reported illness with vomiting, diarrhea, nausea, and cough on 11/21/24. 7) NA-D reported illness with vomiting on 11/21/24. 8) LPN-D- reported illness with vomiting and diarrhea on 11/25/24. 9) NA-E-reported illness with diarrhea on 11/25/24. 11) NA-F-reported illness with diarrhea on 11/26/24 There was no mention of any additional follow up, potential testing or identification of when staff were cleared to be able to return to work. Review of the staff infection control log for December 2024 identified 1 staff illness. NA-F-reported ill with no S/S identified and was tested positive for COVID-19. There was no mention of any additional follow up, potential testing or identification of when staff were cleared to be able to return to work. Review of the staff infection control log for January 2025 identified 3 staff illness: 1) An unidentified staff reported illness of vomiting, nausea, and headache on 1/4/25. 2) NA-E reported illness of flu symptoms on 1/9/25. 3) RN-A reported illness of vomiting and fever on 1/13/25. There was no mention of any additional follow up, potential testing or identification of when staff were cleared to be able to return to work. Interview on 1/27/25 at 5:00 p.m., with the director of nursing (DON) identified there was no documentation of the type or when TBP had been initiated on the surveillance logs. She also observed the staff illness tracking and confirmed the documentation was incomplete and should have listed staff S/S, time off work, date of return, and if they had been seen by a medical provider or had any testing for illness completed. When a staff call in was reported either she or the scheduling coordinator were to attempt to contact the employee to discover the reason for call in if it was not documented. Interview on 1/27/25 at 6:27 p.m., with LPN-E identified LPN-E worked as the charge nurse and if a staff person called in for themselves of a child, she would use the provided illness form, document the name of the staff person, S/S if they were provided and if they reported plan to see a medical provider. If they were calling in for a child, she might ask for the S/S, but reported she was not certain if she had done so. She stated the ill slip was then given to the scheduler, but she was not certain what happened after that. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 1/27/25 at 6:34 p.m., with RN-B identified when a staff member called as ill, she recorded the information in the binder located at the nursing station and had spaces to record S/S, time of the call, and if the staff member was seeing a provider. She reported she recorded the information that was given, but the person calling in, did not always give the information. She stated the form was routed to infection control, but she was not aware of any follow up process. Interview on 1/29/25 at 9:08 a.m. with the infection preventionist (IP) identified she agreed employee tracking was incomplete and noted she failed to include determination of S/S, if the employee was seeing a medical provider and when it was appropriate for them to return to duty. She did receive calls from staff at times about a family member's illness, but did not perform tracking or trending or follow up about potential precautions due to contact. Interview on 1/29/25 at 11:13 a.m., with the scheduling coordinator confirmed she was only aware of one call in for a staff member in December who tested positive for COVID and three call ins for January 2025 one with flu symptoms and two with no S/S identified. She confirmed when a staff called in ill, they were supposed to give the reason for their absence, if they were seeking medical attention, and S/S of either their or family member's illness but confirmed this did not consistently occur. Following receipt of the paper slip, her job was to enter the information into the electronic employee illness log but was not aware of who/what/when reviewed further. WHIRLPOOL Interview on 1/28/25 at 10:15 a.m. with the environmental services (EVS) manager identified the whirlpool tub as a jetted [NAME] tub with water jets.The disinfectant used as CenKleen IV-Quaternary Ammonium compound disinfectant mixed at ratio of 1 ounce/gallon and filled by EVS staff for nursing staff to be used for cleaning and disinfecting the tub. Observation and interview on 1/29/25 at 3:30 p.m. with NA-G as she cleaned and disinfected the [NAME] Spa tub identified NA-G returned the bath chair to the tub and secured the door. She retrieved the quart spray bottle of Cev-Kleen IV cleaner, applied gloves placed the plug in the bottom of the tub, and using the spray bottle sprayed all surfaces of tub and chair by with the spray bottle. She then ran water into tub to above the level of the jets. While the tub was filling with water, she used a long-handled brush to bush the surfaces of the tub and chair by dipping the brush into the water and then onto the sprayed surface of the tub and chair. NA-G pushed the button labeled jet rinse and stated she held it for a few seconds. NA-G reported she allowed the solution to sit for 1-3 minutes to allow it to disinfect the surfaces and used the hand sprayer to spray off all surfaces. No clock or timer was observed in the tub room. As she waiting the solution on the sides of the tub and chair were observed to be drying. When asked how long she needed to wait, since there was no clock in the room, NA-G replied she had looked at her watch and timed it for 2 minutes. She then took the hand sprayer and rinsed off the tub sides and chair, and allowed the solution to drain from the tub and rinsed all surfaces again. NA-G released the latch on the back of the tub and reported she left the seal open, so it was able to dry. She was not aware of an instruction sheet being posted in the tub room and identified that was how she had been trained to clean and disinfect the whirlpool tub and was unaware of manufacturer's instructions requiring a specif amunt of disinfectant to be infused into the water in the base of the well and run for 10 min, keeping surfaces wet was required for appropriate disifection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the [NAME] Spa Tub manufacture's guide for cleaning and disinfection of the tub following resident bath listed: 1) The tub was to be rinsed initially rinsing all surfaces with the shower sprayer, 2) Drain any water, and then refill by pressing the disinfect button which allows the properly mixed cleaning solution to run through the system. 3) Release the button after you see solution coming out of the jets and have 1 1/2 gallons of disinfectant solution in the foot well of the tub. 4) Scrub all surfaces of the tub and chair with the solution that remains in the well of the tub 5) Let disinfectant remain on the surface for 10 minutes or as recommended on the disinfectant container. 6) Remove the plug from the drain. 7) Rinse the soapy water away. 9) Press and hold the rinse button until water runs clear. Interview on 1/27/25 at 5:00 p.m., with the director of nursing (DON) identified she was not aware there was no longer a sign with cleansing/disinfecting instructions posted in the tub room. She stated her expectation for the tub to be cleansed and disinfected according to the manufacturer's instructions. Both the ADON and DON reported they would take immediate action to correct the procedure. Later interview on 1/29/25 at 11:20 a.m., with the DON identified she had reviewed the manufacture's guidelines for the whirlpool tub and confirmed staff were not following the manufacture's guidelines. Review of the 3/15/24, infection control plan identified the IP and committee were to develop evidence-based national guidelines in the development of the infection prevention and control program. The employee illness log was identified as available on the facility's shared drive with each department head responsible to log sick time utilized by their employees. The nursing home was identified as responsible for sending their data to the IP monthly with the information to be reviewed at the infection control meetings. The Center for Disease Control (CDC) National Healthcare Safety Network (NHSN) surveillance methodology was to be utilized by the facility. The IP was to coordinate and review infection control issues and summarize and report to the Infection Control committee. Review of the 1/29/25 Bath- Shower/Tub - Level II policy failed to identify the procedure for cleaning and disinfecting the whirlpool tub according to manufacturer's guidelines following resident bathing.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 34083 Based on interview and document review, the facility failed to implement a comprehensive antibiotic stewardship program with antibiotic Time Outs (ATO) (formal review of a patient's antibiotic therapy that occurs 48-72 hours after the initial dose), or evaluation of continued need for antibiotic treatment for 3 of 3 residents (R6, R15 and R28). This has the potential to affect any resident receiving antibiotic treatment. Findings include: Interview and document review identified: R6's medical record (MR) identified a 1/18/24, physician (MD) order for Macrobid (an antibiotic used to treat urinary tract infections (UTIs)), 50 milligrams (mg) by mouth (PO) every (Q) evening (PM), for UTI prevention. The medical record failed to identify any urine cultures or sensitivity (UC/US) completed following the MD order, and no ATO for continued need of the medication. The record also failed to identify any non-pharmacological interventions attempted. R15's medical record identified a 1/21/25 MD orders for Macrobid 100 mg PO x 5 days for UTI. The record failed to include any criteria implemented nor was there documentation of an ATO completed. R28's medical record identified a 12/18/24 MD orders for Macrobid 100 mg PO twice daily (BID) x 10 days. The record failed to identify any criteria identified prior to initiation of the antibiotic. R28 developed a rash, and the antibiotic was changed on 12/29/24 to Ertapenem 1 gram (GM) intramuscularly (IM) x 5 days. A UA/UC was completed, and Ertapenem 1 gm IM X 10 days was reordered. A UA/UC was again completed on 1/27/25 with negative results. R28 received antibiotics from 12/29/24 through 1/23/25 with no criteria documented prior to requesting a UA and antibiotics and ATOs were not completed during this time. Interview on 1/27/25 at 5:00 p.m. with the director of nursing (DON), reported the infection preventionist (IP) had emailed her the information to provide, reported there was not consistent documentation of criteria used for updating the provider prior to requesting an antibiotic for a UTI, nor were ATO being completed. The DON identified there had been a meeting on 1/24/25 with the DON, ADON, IP, medical director, in-house pharmacist, and a nurse practioner(NP) to discuss antibiotic stewardship, criteria to be utilized for updating the provider of a resident with a potential UTI, ATOs, and the development of individualized care plans for those residents who demonstrated S/S outside the parameters and the inclusion of that information on the Standing Order Set. There was nothing implemented prior to the survey after it was identified. Interview on 1/27/25 at 5:43 p.m., with the medical director identified he had attended the meeting on 1/24/25 with discussion of guidelines for antibiotic stewardship and what criteria was to be use in the facility. He reported they had discussed current trends, with antibiotic use, and criteria such as Loeb's, or McGeer's to include in determining the use of antibiotics. He identified his agreement for review and documentation of a resident that had orders for a prophylactic antibiotic for a UTI and it should not just be assumed that an ongoing order was sufficient. ATO should be completed. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 1/29/25 at 8:45 a.m., with the IP reported she attended morning meetings which included discussion of infections, wounds, changes in resident status, laboratory tests completed. She reported she would then follow up by checking EPIC (medical record application) for any new infections, labs, then follow up for orders for UTIs and C/S. She was aware two residents were currently receiving prophylactic antibiotics. The IP stated the nursing staff was going to use Loeb's as the criteria for requesting UA/UC, and her understanding was they had the criteria posted at the nursing station. She was not aware it was not being utilized, and ATO were not currently being completed and documented according to facility policy. Review of the September 15, 2022, Antibiotic Stewardship Policy for Long Term Care Identified the need for treatment of infections with the promotion of appropriate use of antibiotics. A monthly tracking report was to include summary of data collected with review by the consulting pharmacist, and IP with reports to the Quality Assurance Committee. Areas to be identified with antibiotic orders included: Resident name, antibiotic name, indication for the medication, route, dose, length of treatment, who prescribed the order, Antibiotic time out-yes/no, the record was to be reviewed, and information recorded in the e Excel database with review by the consulting pharmacist. ATO were to be collected and reported monthly for all antibiotics ordered whether from an outside or inside facility source.