



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 15, 2024

Administrator
Saint Anne Extended Healthcare
1347 West Broadway Street
Winona, MN 55987

RE: CCN: 245233
Cycle Start Date: December 14, 2023

Dear Administrator:

On January 3, 2024, we notified you a remedy was imposed. On February 8, 2024 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 17, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 18, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 3, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 18, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 17, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Correction of the Life Safety Code deficiency(ies) cited under K372 and K541 at the time of the December 14, 2023 standard survey, has not yet been verified. Your plan of correction for these deficiencies, including your request for a temporary waiver with a date of completion of February 7, 2024 and March 6, 2024, has been forwarded to the Region V Office of the Centers for Medicare and Medicaid Services (CMS) for their review and determination. Failure to come into substantial compliance with these deficiencies by the dates indicated in your plan of correction may result in the imposition of enforcement remedies.

Saint Anne Extended Healthcare

February 15, 2024

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Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "M. Poepping". The signature is fluid and cursive, with a large initial "M" and a stylized "Poepping".

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 15, 2024

Administrator
Saint Anne Extended Healthcare
1347 West Broadway Street
Winona, MN 55987

Re: Reinspection Results
Event ID: 43BX12

Dear Administrator:

On February 8, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 14, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 3, 2024

Administrator
Saint Anne Extended Healthcare
1347 West Broadway Street
Winona, MN 55987

RE: CCN: 245233
Cycle Start Date: December 14, 2023

Dear Administrator:

On December 14, 2023, a survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 18, 2024.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 18, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 18, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by January 18, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Saint Anne Extended Healthcare will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 18, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 14, 2024 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and

1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <https://forms.web.health.state.mn.us/form/NH-Dispute-Resolution>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/16/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245233	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/14/2023
NAME OF PROVIDER OR SUPPLIER SAINT ANNE EXTENDED HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1347 WEST BROADWAY STREET WINONA, MN 55987		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments On 12/11/23 - 12/14/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 12/11/23 - 12/14/23 a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed The following complaints were reviewed with NO deficiency issued: H52337964C (MN99117), H52337703C (MN93697), H52337704C (MN93084), and H52337705C (MN86673). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/10/2024

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

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F 000	Continued From page 1 be used as verification of compliance.	F 000			
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she	F 578			1/17/24

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F 578	Continued From page 2 has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure a resident's code status was consistent across the Electronic Medical Record (EMR) and paper chart for one of 10 residents (R46) reviewed for advanced directives. Finding include: R46's Face Sheet, indicated R46 was admitted to the facility on 7/27/21 with a primary diagnosis of hemiplegia and hemiparesis following a cerebral infarction affecting her left, non-dominant, side. The banner at the top of R46's face sheet further indicated R46's code status was do not resuscitate (DNR)/ do not intubate (DNI). R46 physician order, dated 8/5/22, indicted R46's code status was DNR/DNI. R46's Provider Order for Life-Sustaining Treatment (POLST), dated and signed by R46 on 12/13/2019, indicated R46 would like cardiopulmonary resuscitation (CPR) if she had no pulse and/or was not breathing and would like full treatment to include intubation, advanced airway interventions and mechanical ventilation as indicated.	F 578	Facility has systems in place to ensure most recent Advance Directives or POLST is documented in both electronic medical record and hard chart. All hard charts have been reviewed and compared with electronic medical record and any discrepancies have been corrected. Additionally, going forward the resident's chart will be reviewed at the quarterly care conference to ensure MD order for code status matches the Advanced Directive or POLST in hard chart. Facility has reviewed Medical Orders (POLST and OHDNR) policy for accuracy. Re-education for nursing staff and social workers regarding reviewing the MD order, POLST, and Advanced Directives to ensure they match. The Medical Orders policy will also be reviewed. Social Workers will be responsible for implementation of workflow. Audit to ensure compliance will include		

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F 578	Continued From page 3 R46's Health Care Directive, dated and signed by R46 on 8/30/21, indicated R46 would like CPR attempted if her heart or breathing stopped, based on her current state of health. A Care Conference Progress Note, dated 8/5/22, indicated R46 had changed her mind on her code status and wished to be DNR. During observation 12/12/23 at 2:00 p.m., R46's paper chart behind the nursing station contained R46's face sheet as the first page, indicating R46 was DNR/DNI. Directly behind R46's face sheet was R46's Health Care Directive which indicated R46 was full code and would like to be resuscitated. During an interview on 12/12/23 at 2:23 p.m., licensed practical nurse (LPN)-D stated she would use the "Banner" in the EMR to know a resident's code status and stated R46's code status was DNR/DNI. During an interview on 12/12/23 at 3 p.m., nurse manager and registered nurse (RN)-A stated the best place to look for a resident's code status was the "Banner" in the EMR as that was the most accurate information. During an interview on 12/14/23 at 10:40 a.m., nurse manager and RN-A stated they used a checklist to indicate what documents to send with a resident when then needed to go to the hospital. Among those documents to send to the hospital with the resident was the POLST and physician orders. RN-A confirmed these documents for R46 would contain conflicting information with the orders stating DNR and the	F 578	review of Matrix report on a quarterly basis ensuring advanced directives, MD order and POLST all contain same information. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. The Director of Nursing or their designee is responsible for the monitoring of this plan of correction.		

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F 578	Continued From page 4 POLST stating full code. During an interview on 12/14/23 at 12:10 p.m., the director of nursing (DON) stated she would expect the information on code status to match, acknowledging there was conflicting information in R46's chart. A facility policy on code status and advanced care planning was reviewed.	F 578			
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items	F 582			1/17/24

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F 582	Continued From page 5 and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to fully and accurately complete the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) (Form CMS-10055) for two of three residents (R13 and R64) reviewed for beneficiary notices. Findings include: The SNFABN contains a section with three options for the resident or resident representative to select. Option One indicates the resident would	F 582	Facility has systems in place to ensure proper workflow is being followed when issuing the SNF Advanced Beneficiary Notice of Medicare Non-Coverage. Facility has reviewed the Medicare Beneficiary Policy and the Guidance for Ending SNF Medicare Coverage for accuracy. Re-education for MDS Coordinators, Business Office, Administrator, DON,		

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F 582	Continued From page 6 like the care listed above and recognizes payment responsibility but would like Medicare to be billed for an official decision on payment, Option Two indicates the resident would like the care listed above and recognizes payment responsibility but does not want Medicare billed and Option Three indicates the resident does not want the care listed above. R13's face sheet, indicated R13 was admitted to the facility on 1/11/23 with a primary diagnosis of senile degeneration of the brain. R13's Progress Note, dated 6/21/23, indicated R13's skilled services would be ending on 6/23/23 with financial liability beginning on the "following date." The progress note detailed a phone conversation with R13's daughter regarding the SNFABN but failed to identify what option R13 would like for her care. R64 face sheet, indicated R64 was admitted to the facility on 8/11/23 with a primary diagnosis of encounter for orthopedic aftercare following surgical amputation. R64's SNFABN, dated 11/14/23, indicated R64's skilled services would be ending on 11/16/23 with financial liability beginning on 11/17/23. The form was signed by R64 on 11/14/23 but did not indicate which option he wanted for his care. During an interview on 12/13/23 at 9:57 a.m., licensed practical nurse (LPN)-F stated her process was to issue the SNFABN regardless of whether a resident discharging from Medicare A was discharging to the community or the facility. LPN-F stated it was the resident's and/or the resident representative's decision on which of the	F 582	Quality Manager, and Admissions Nurse will include review of this policy, Guidance for Ending SNF Medicare Coverage, and how to correctly complete the form. Quality Manager will be responsible for implementation of workflow. Audit to ensure compliance will include review of documentation related to accurate completion of Notice of Medicare Non-Coverage during Triple Check Audit process each month. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. The Director of Nursing or their designee is responsible for the monitoring of this plan of correction.		

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F 582	Continued From page 7 three options listed on the SNFABN to select. LPN-F stated R13's representative should have been followed up with to obtain the signed SNFABN and to determine which option they would like for R13's care. LPN-F further stated R64 should have been followed up with to determine which option he would like for his care on the SNFABN as he was cognitively intact to make the decision on his own. During an interview on 12/14/23 at 12:10 p.m., the director of nursing stated she would expect an option to be selected on the SNFABN and for the residents who did not have an option selected to be followed up with. A facility policy titled Beneficiary Notices, revised on 11/2017, indicated the facility would provide beneficiary notices according to Medicare guideline.	F 582			
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide appropriate care in a timely manner to prevent a decline in condition for 1 of 1 residents (R32) when R32	F 684	Facility has systems in place to ensure proper workflow is being followed when a resident experiences a change in condition.		1/17/24

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F 684	Continued From page 8 continued to experience prolonged nausea and decline lasting more than three weeks causing harm. As a result, R32 was sent to the emergency department (ED) and admitted to the intensive care unit (ICU) after the facility failed to ensure the provider was fully appraised of R32's signs and symptoms. Findings include: R32's admission Minimum Data Set (MDS) assessment dated 10/15/23, indicated R32 was admitted to the facility on 10/9/23 after a right knee fracture, had moderate cognitive impairment and was dependent on staff for toileting, bathing, personal hygiene, transfers, and locomotion. During an interview on 12/11/23 at 3:59 p.m., R32 stated she had not seen a physician in person since she had started feeling sick, stating she was nauseated "all the time" and was not able to eat much due to her nausea. R32 stated she was able to tolerate the pain from her fracture but could not "live with this nausea." During an interview and observation on 12/13/23 at 10:40 a.m., R32 stated she "just wanted to get better" but did not want to go to the hospital. Stating she continued to feel nauseated "all the time." R32 was pale in color. R32's progress notes indicated the following: 11/21/23 R32 complained of being nauseated with little appetite, stating she felt like "spitting up." 11/23/23 R32 tested positive for COVID. The nurse practitioner (NP) was updated and started	F 684	Facility has reviewed Change in Condition policy for accuracy. In daily IDT meeting, all disciplines have discussed residents who have experienced a change in condition and formulated a plan of care. Nurse Supervisors are running daily FAR report and reviewing progress notes for any abnormalities. This information is being discussed at the daily IDT meeting as needed. Re-education for licensed nursing will include review of Change in Condition policy, Interact tools in Matrix, Benedictine Documentation Change in Status training, and Benedictine Documentation Care Planning training. Nurse Supervisor will be responsible for implementation of workflow. Audits to ensure compliance will include Nurse Supervisors daily review of progress notes and Facility Activity report 24 for the past 24 hours to monitor for change in status and follow up as needed and determine plan of care. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. The Director of Nursing or their designee is responsible for the monitoring of this		

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F 684	Continued From page 9 R32 on Mirtazapine for appetite stimulant. 11/27/23 R32's nausea was continuing. R32 stated, "I can't eat if I'm always nauseated." 11/28/23 R32 had a "spell" in the bathroom where her colored turned pale, her head lowered and she "came back around after a few seconds." It was also documented R32 had 2 loose stools, black in color. R32 stated "not right now" when offered to be sent to the hospital. 11/29/23 the nursing assistant (NA) found R32 to be unresponsive while changing her brief. The nurse was called to the room and found R32 with "brownish liquid" coming from her mouth. R32 did not respond when the nurse called her name or "shook" her. When R32 "came around" she was asked if she wanted to be seen in the emergency department and refused. 11/29/23 R32 had a loose, "blackish" stool and was noted to have a spot of darkened blood on her gown. R32's daughter in law was updated on the "small spell" in the bathroom on 11/28/23. 11/30/23 a referral for hospice was made and R32 continued to have loose black stools. The note indicated the medical director (MD) would be updated on the hospice consult. 12/2/23 R32's appetite remained poor, R32 stated "I'm so sick to my stomach, I can't eat," The note indicated R32 was having a difficult time taking medications. 12/3/23 R32 had complaints of nausea. R32 became tearful when she was too weak to transfer on her own.	F 684	plan of correction.		

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F 684	Continued From page 10 12/4/23 R32 stated she was nauseated, had a difficult time taking medications and did not eat any breakfast. 12/4/23 R32's weight was declining due to R32 refusing most meals and was being followed by the registered dietician (RD). 12/5/23 R32 continued to state feeling "sick to my stomach" and did not eat any breakfast. 12/6/23 R32 continued to have multiple loose stools, stating "I can't eat if I am nauseated all the time." The nurse practitioner (NP) was informed and gave an order for as needed (PRN) Zofran (an antiemetic that can prevent nausea and vomiting). 12/7/23 R32 received an order from the provider for occupational therapy for lymphatic treatment and massage due to new swelling of her lower extremities. 12/8/23 the MD was updated about R32 having bleeding gums. R32 continued to have "slight nausea." 12/8/23 the MD ordered labs to be obtain to include BMP and CBC with differentials due to concerns with bleeding gums. 12/8/23 R32's "platelets within normal limits (WNL) and do not indicate a bleeding concern. R32 continued to have nausea and loose stools. 12/9/23 R32 had a negative COVID test and was removed from COVID isolation.			F 684			

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F 684	Continued From page 11 12/11/23 R32 became upset she was feeling "so rotten" all the time and had no breakfast. R32 was documented as being pale in color. 12/11/23 R32 continued with nutritional decline and significant weight loss. The RD met with R32 who stated she "can't keep anything down" due to her ongoing nausea. 12/11/23 R32 had complaints of nausea and diarrhea. R32 had two stools that shift and had two "spells" of passing out while being transferred to the toilet. It was documented with both episodes she became "flaccid" and during the second episodes had difficulty holding her head up. 12/12/23 R32's daughter in law was updated regarding the "evening shift toilet episodes" and R32 continued to not eat and remain nauseated "even after Zofran" was given. R32 was noted to have four loose stools that shift. 12/13/23 it was documented R32 had a "spell" of unresponsiveness at 4:00 a.m. While being transferred R32 had "explosive, loose, dark stool" stating she felt sick, holding her mouth as if to vomit. R32 progressively became unresponsive, bowing her head. Progress note included, R32 had "flaccid, arms barely supporting her weight on the sling". On coming shift was updated. 12/13/23 R32 refused breakfast and when R32 attempted to sit on the side of the bed she stated she needed to lay back down and was pale and nauseated. B/P was 67/45 while up and 92/60 when laying back down. R32 stated, "why do I feel so sick?" Medications were held and supervisor was updated.	F 684			

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F 684	Continued From page 12 12/13/23 the NP decided R32 should be sent to the hospital for evaluation. R32 was "okay" with going to the hospital if they could get her to feel better. 12/13/23 R32 was in the ICU with a potential GI bleed. R32's family refused diagnostic testing for confirmed GI bleed but okayed R32 receiving a blood transfusion for low hemoglobin. R32's electronic medical record (EMR) indicated R32 had a face-to-face provider visit twice since admission. On 10/26/23 the MD saw R32 for her admission visit and on 11/22/23 the NP saw R32 for a routine visit. R32's Active Orders list indicated the following medication orders: amlodipine 2.5 milligrams (mg) daily (a high blood pressure medication), adjusted on 12/12/23; lisinopril 5mg daily (a high blood pressure medication), adjusted on 12/12/23; ferrous sulfate 325 mg daily (iron supplement), dated 11/1/23; Eliquis 5mg twice a day (a blood thinner medication), dated 10/9/23; and Zofran 4 mg every eight hours PRN for nausea and vomiting. R32's care plan lacked interventions to address R32's frequent and continued nausea and diarrhea described as loose and black in color. During an interview on 12/13/23 at 2:58 p.m., the rehab social worker (SW) stated she reached out to the hospice social worker after the hospice meeting on 11/30/23, who stated family was waiting on an x-ray scheduled for 12/4/23 to decide if they wanted to continue with therapy or pursue hospice. The SW was unsure if staff had	F 684			

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F 684	Continued From page 13 followed up with family after the x-ray on 12/4/23. R32's EMR lacked evidence the family had been re-approached about hospice care versus continuing with therapy after the x-ray on 12/4/23. R32's Physical Therapy Treatment Encounter Note, dated 11/28/23, indicated physical therapy (PT) entered R32's bathroom, R32's head was hanging down and she was not responding to verbal or tactile cues. R32 began saying a few words after several minutes but was not responding appropriately. Session ended due to "patient medical condition." R32's Physical Therapy Treatment Encounter Note, dated 12/11/23, indicated R32 was complaining of an upset stomach after sitting on the edge of the bed. The note indicated R32 was receiving nausea meds but was unsure if they were helping. R32 stated she wanted to get better but was unable to continue with the therapy session due to an upset stomach. R32's Physical Therapy Treatment Encounter Note, dated 12/13/23, indicated R32 had complaints of feeling like she was going to pass out when sitting on the edge of the bed. The note indicated R32 was "still not eating or drinking daily due to nausea" and had been taking nausea medicine daily without a notable difference. Therapy session was stopped due to R32's medical condition. During an interview on 12/13/23 at approximately 9 a.m., occupational therapist (OT)-A stated she had an order to see R32 for lymphedema treatment due to increased swelling in her lower extremities. OT-A stated due to R32's low blood	F 684			

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F 684	Continued From page 14 pressure and continued nausea she would not be medically stable enough for lymphedema treatments. During an interview on 12/13/23 at 9:15 a.m., NA-A stated R32 was often nauseated and weak, stating "they just want us to use the bed pan and push fluids". During an interview on 12/13/23 at 10:15 a.m., licensed practical nurse (LPN)-D stated she would not update the provider if there was a concern with a resident or a change in condition, as she would let the charge nurse know, even on the weekends. LPN-D stated R32 "hadn't been good lately" and has been sick on and off for a few weeks. LPN-D confirmed utilizing R32's PRN Zofran the past couple of days, stating it was not working. During an interview on 12/13/23 at 11:30 a.m., the assisted director of nursing (ADON) stated R32 came to the facility for rehab due to a knee fracture and did not have a good appetite since admission and would make statements she was ready to go to heaven. During review of the EMR, the ADON confirmed R32 had not seen a provider since 11/22/23 but on 11/1/23 labs were drawn and an iron supplement was started, 11/23/23 Mirtazapine was started as an appetite stimulant, 12/6/23 Zofran was started (14 days after first onset of nausea), 12/7/23 orders were received for occupational therapy, 12/8/23 labs were completed and on 12/11/23 blood pressure medications were adjusted. The ADON was unaware R32's unresponsive episodes started on 11/28/23 and was under the impression the first episode was early that morning. The ADON stated she would like to be updated on R32's	F 684			

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F 684	Continued From page 15 unresponsive episodes but it was "unrealistic" to know about them all and she expected the nurses to update the providers on any change in condition. The ADON was also not aware the Zofran was ineffective for R32 stating, "apparently it is not working if she is still nauseated." The ADON stated they had recommended hospice, but the family was still undecided on hospice versus continuing to treat with therapy. During an interview on 12/13/23 at approximately 2:00 p.m., the NP stated she sent R32 to the hospital due to her low blood pressure. The NP stated she aware of R32's unresponsive episode early that morning but was unaware they started back at the end of November, stating she would like to be made aware of every episode but not necessarily the same day they happened. Further, the NP was unaware of the uncontrolled nausea, stating she had initiated the Zofran but was not aware it was not working. The NP did confirm she was aware of the black tarry stool, stating since R32 was on iron it was hard to tell if it was related to her low blood pressure readings. (Black stool is often a sign of gastrointestinal bleeding, but not always. Certain medications and supplements, such as iron, may turn stool black.) During an interview on 12/14/23 at 10:19 a.m., the medical director (MD) stated she met R32 for her initial visit on 10/26 and that was the only time she met with R32. The MD stated R32 came to the facility with a knee fracture and history of dementia. She was doing therapy but not participating well. The MD stated she was aware of R32's poor appetite and had started mirtazapine for an appetite stimulant. She was aware R32 was started on Zofran for nausea and had started cutting back on some medications on	F 684			

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F 684	Continued From page 16 12/12/23. The MD further stated R32 would be a good candidate for hospice. The MD stated she was not personally aware of R32's multiple unresponsive episodes, the episodes of loose, black stools, the brown liquid found coming from R32's mouth or that her nausea remained uncontrolled. The MD stated she was notified of possible bleeding gums, which was why she had ordered labs on 12/8 but not of the brown liquid coming from R32's mouth while unresponsive or the loose black stool. The MD further stated she would want to be made aware of these episodes but not necessarily the day they occurred, stating she did not believe she had a full picture of R32's condition, stating multiple providers were made aware of different situations making it difficult to see the full picture, as many of these signs and symptoms indicate a potential GI bleed. The MD stated she would have approached R32's care different had she been aware, starting a proton pump inhibitor (a class of medications that cause a profound and prolonged reduction of stomach acid production), more routine hemoglobin checks, more intensive interventions for her nausea and a more forward conversation about goals of care with R32 and her family to appropriately address R32 with either treatment focused interventions or comfort care. The MD stated R32's hemoglobin went from 11.3 to 9.6 this morning, stating she would suspect a GI bleed until it was ruled out, stating the only way to conclusively tell would through an endoscopy (a flexible instrument inserted through the mouth or rectum to view the inside of the GI tract). During an interview on 12/14/23 the director of nursing (DON) stated R32 had been addressed at their interdisciplinary team (IDT) meetings and she would have expected the nurses to "take			F 684			

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F 684	Continued From page 17 care of it." The DON stated she did not want R32 back to the facility without a clear plan of either treatment or comfort focused care. A facility policy titled Change in Condition, reviewed 10/2/23, indicated when a significant change in the resident's physical, mental or psychosocial status is identified by the license nurse, or when there is a need to alter treatment significantly. The licensed nurse consults with attending provider or the medical director.	F 684			
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F 755			1/17/24

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F 755	Continued From page 18 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure narcotics were counted in a manner to detect potential diversion at shift change for 2 of 7 medication carts reviewed. Findings include: On 12/12/23 at 2:50 p.m., licensed practical nurse (LPN)-B on-coming staff and LPN-C off-going staff counted narcotics in two carts. LPN-B unlocked the drawer and would call out the group number and the page number. LPN-C would look for the page number in the narcotic book and LPN-B would say how many pills or milliliters (ml) if it was a bottle with liquid. LPN-C would confirm the number or ml was correct. The index page and/or paging through each page was not used to ensure all medications were accounted for. LPN-B stated the on-coming staff was in the drawer and the off-going staff was looking in the book. On 12/12/23 at 2:58 p.m., LPN-B stated unless they looked at each page in the book they would not know if a card or bottle was missing. LPN-B verified they did not review each page and not all medications had been signed into the index page of the narcotic book.	F 755	Facility has systems in place to ensure proper workflow is being followed when new narcotic Rx has been delivered from the pharmacy. Facility has reviewed the Controlled/Scheduled II-V Medications policy for accuracy. Re-education for licensed nurses will include training on completing the index page of the narcotic book when a new narcotic Rx has been delivered from the pharmacy. Training will also address using the index page of the narcotic book as a tool to reference the corresponding pages in the narcotic book that will state the name of medication and number of doses remaining. Nurse Supervisor will be responsible for implementation of workflow. Audit to ensure compliance will include weekly audit reviewing accurate completion of index page of narcotic book. Results of monitoring shall be reported at the facility Quality Council meeting with		

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F 755	Continued From page 19 On 12/12/23 at 3:02 p.m., registered nurse (RN)-A stated the process was to use the index page to sign in all narcotics. In addition, RN-A stated staff needed to use the index page to count narcotics at shift change would to ensure all medications were accounted for. RN-A verified the index pages had medications not signed into the book, three of 40 were not signed into book one, seven of 40 were not signed into book two, two of 40 were not signed into book four, and four of 12 were not signed into book five. On 12/12/23 at 3:15 p.m., RN-B stated the process for the narcotic count would be to check each page to ensure all medications were accounted for and correct. RN-B stated staff should be signing all narcotics into the book using the index page and filling out the information on the corresponding page. On 12/12/23 at 3:21 p.m., the assistant director of nursing (ADON) verified the books had missing entries for narcotics on the index pages of the narcotic books. The ADON verified when staff complete the narcotic count at shift change they should be counting from the book (checking each page) to ensure each medication is accounted for. On 12/12/23 at 3:34 p.m., the director of nursing (DON) verified it was best practice to sign each narcotic into the index page and fill in the information on the corresponding page. The DON verified staff should look at each page to ensure all narcotics were counted and accounted for to prevent diversion. On 12/14/23 at 9:31 a.m., the consultant pharmacist (CP) verified staff should count	F 755	ongoing frequency and duration to be determined through analysis and review of results. The Director of Nursing or their designee is responsible for the monitoring of this plan of correction.		

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F 755	Continued From page 20 narcotics from the book to ensure no medications were missing from the cart. Medication Ordering And Receiving From Pharmacy dated 4/1/19, directed staff to do the following: "Controlled substance inventory sheets are completed, if necessary , and filed appropriately. A hard-bound log book is utilized to track the controlled substance from delivery to disposition. "	F 755			
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure they were free of a medication error rate of five percent or greater. The facility had a medication error rate of 6.9 % with two errors out of 30 opportunities for error involving 2 of 6 residents (R73, R61)who were observed during the medication pass. Findings include: R73's annual Minimum Data Set (MDS) assessment dated 10/8/23, identified R73 was severely cognitively impaired and had diagnoses which included cancer, diabetes mellitus, dementia, and depression.	F 759	Facility has systems in place to ensure proper workflow is being followed when administering medications to ensure accuracy. Facility has reviewed Specific Medication Administration Procedures policy for accuracy. Re-education for licensed nurses and TMA's will include review of Specific Medication Administration Procedures and proper use and labeling of medications. All insulin pens, vials and eye drops must have an open date documented on the product. All eye drops must have specific		1/17/24

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F 759	Continued From page 21 R73's Physician Order Report identified R73 had orders as follows: -10/9/23, Humalog insulin 100 units per milliliter (ml) 17 units subcutaneously once a day between 11:00 a.m. and 1:00 p.m. On 12/12/23 at 12:18 p.m., during an observation licensed practical nurse (LPN)-A prepared Humalog insulin for R73 by scrubbing the hub of the pen, placing a disposable needle on the pen and priming the needle by dialing two units and wasting the insulin. LPN-A then dialed up 17 units of insulin and proceeded to R73's room. -at 12:22 p.m., LPN-A was stopped and asked about the open date for the insulin pen. LPN-A looked at the pen again and was unable to locate an open date. LPN-A said insulin was good for 28 days after opening and because she could not locate an open date she should not give the insulin she prepared and should discard the pen and get a new pen. LPN-A then removed a new insulin pen for R73 and scrubbed the hub, wasted two units of insulin and dialed up 17 units of insulin and then proceeded to R73's room and administered the insulin from the new pen. On 12/12/23 at 12:30 p.m., during an interview LPN-A stated the importance of dating insulin pens was to ensure the insulin was not used past 28 days to ensure the insulin would still be effective. R61's quarterly MDS assessment dated 10/3/23, indicated R61 was cognitively intact and had diagnoses which included cerebrovascular accident (stroke), hypertension, and hemiplegia and hemiparesis (loss of strength or paralysis on	F 759	directions attached to the product. Nurse Supervisor will be responsible for implementation of workflow. Audit to ensure compliance will include weekly audit of medication cart by Nurse Supervisor/designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. The Director of Nursing or their designee is responsible for the monitoring of this plan of correction.		

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F 759	Continued From page 22 one side of the body). R61's Physician Order Report identified R61 had orders as follows: -5/31/23, refresh relieva one drop ophthalmic eye twice a day morning and bedtime med pass On 12/13/23 at 8:26 a.m., during an observation trained medication aide (TMA)-A was preparing medications for R61. TMA-A picked up a bottle of refresh tears with an open date of 10/23/23, and an expiration date of 3/2026. TMA-A stated she was not sure if the eye drops were for both eyes or just one eye. TMA-A asked LPN-A what to do and was told to place one drop in both eyes. TMA-A had R61 tip their head back and placed a drop in each eye. On 12/14/23 at 9:26 a.m. the consultant pharmacist (CP) stated the staff should have checked the order for clarification and if the details were missing they should have held the eye drops until they received that clarification. On 12/14/23 at 10:49 a.m., the director of nursing (DON) stated if an insulin pen was not dated the staff should have done one of two things. One would be to throw the insulin pen away, the second would be to check the send date from the pharmacy and if it was within the 28 days the pen could be dated as opened on the send date and use the pen up to the 28 days. In addition, the DON stated if the route for eye drops was not specified in the order (for example right eye, left eye, or both eyes) the staff should not administer the eye drops until the order was clarified. Preparation and General Guidelines dated 4/1/19	F 759			

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F 759	Continued From page 23 Medication Administration directed staff to follow the five rights of medication administration, right resident, right drug, right dose, right route, and right time. In addition, the policy directed staff to check the medications for the five rights at 3 steps in the process: when they selected the medication, when the medication was removed from the container and again after the dose was prepared and the medication was being being put away.	F 759			
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761			1/17/24

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F 761	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were labeled appropriately with open dates. In addition, the facility failed to remove expired medications for 6 of 82 residents (R76, R29, R34, R16, R39) whose medications were observed during medication storage. Findings include: During the medication storage tour on the second floor on 12/13/23 at 2:11 p.m., with trained medication aide (TMA)-B there were medications with no open dates and medications/items past the expiration date as listed below: -lantus insulin for R29 with no open date -29 hydrogen peroxide wipes manufacturer's expiration date of 11/9/22 -copper tone sun screen with manufacturer's expiration date of 11/2020 -equate sport sun screen with manufacturer's expiration date of 11/2020 -mineral oil with manufacturer's expiration date of 12/5/22 On 12/13/22 at 2:15 p.m., registered nurse (RN)-A stated medication carts should be checked monthly for expired medications. RN-A stated this was important to ensure residents did not receive medications which had expired. During the medication storage tour on the third floor on 12/13/23 at 2:34 p.m., with licensed practical nurse (LPN)-A antacid tablets with manufacturer's expiration date of 9/2023 were found in the medication cart.			F 761	Facility has systems in place to ensure proper workflow is being followed when labeling medications and handling expired medications. Facility has reviewed Specific Medication Administration Procedures and Disposition and Destruction of Medications Policy for accuracy. Re-education for licensed nurses and TMA's regarding checking for expired medications and proper destruction of medications. If medication is received from pharmacy without proper labelled directions, Nursing will contact pharmacy to have them re-issue the medication with a proper label. Nurse Supervisor will be responsible for implementation of workflow. Audit to ensure compliance will include weekly medication cart audit performed by Nurse Supervisor or their designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. The Director of Nursing or their designee is responsible for the monitoring of this plan of correction.		

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F 761	Continued From page 25 During the medication storage tour on the fifth floor on 12/14/23 at 10:06 a.m., with LPN-E there were medications with no open dates and medications/items past the expiration date listed below: - albuterol inhaler for R34 expiration date of 10/2022 -aspirin 81 milligrams (mg) expiration date of 1/2023 -glycerin eye drops for R16 expiration date of 7/2023 -naphocon-a-sol eye drops for R16 expiration date of 9/15/22 -albuterol inhaler for R39 expiration date of 9/18/23 On 12/14/23 at approximately 10:15 a.m., LPN-E stated it was important to have a process in place to make sure staff were not administering expired medications to residents. During the medication storage tour on the fourth floor on 12/14/23 at 10:27 a.m., with LPN-D dorzolamide timolol eye drops for R76 were found with an expiration date of 7/2023. On 12/14/23 at 9:29 a.m., consultant pharmacist (CP) stated staff should be checking medications in the carts on a regular basis to ensure there were no outdated medications. On 12/14/23 at 10:53 a.m., the director of nursing (DON) stated the staff should be completing cart audits monthly. The DON stated the purpose was to ensure residents were not given outdated medications as they could have lost their effectiveness.	F 761			

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F 761	Continued From page 26 Medication Storage in the Facility dated 4/1/19, included-directed the staff to do the following: "E. The nurse will check the expiration date before administering it. F. No expired medication will be administered to a resident. G. All expired medications will be removed from the active supply and be destroyed in the facility, regardless of the amount remaining. The medication will be destroyed in the usual manner."	F 761			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880			1/17/24

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F 880	Continued From page 27 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880			

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F 880	Continued From page 28 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure communal vital signs machine was disinfected between resident use for 2 of 2 residents (R61, R71) observed to have vital signs checked conducted without proper disinfection of the machine. This practice had the potential to affect all 26 of 26 resident residing on the floor. Findings include: On 12/14/23 at 7:49 a.m., licensed practical nurse (LPN)-A was observed to enter R71's room with the communal vital sign machine. LPN-A proceeded to take vital signs for R71 and exited her room. LPN-A was not observed to disinfect the vital sign machine. There were no disinfecting wipes observed on the vital sign machine. The vital sign machine was left in the hallway, while LPN-A stopped and talked to another staff. On 12/14/23 at 7:51 a.m., LPN-A was observed entering R61's room with the communal vital sign machine that had not been disinfected. LPN-A proceeded to take vital signs for R61. Upon exiting the room, the communal vital sign machine was placed by the nursing station, by the scale without being disinfected. During interview with LPN-A, on 12/14/23 at 8:05 a.m., they stated that they had taken numerous residents vital signs this morning. They stated it is expected to disinfect the vital sign machine between each resident, the importance of this as			F 880	Facility has systems in place to ensure proper workflow is being followed when disinfecting equipment in between resident use. Facility has reviewed Cleaning, Disinfection, and Sterilization – Overview policy, Low-Level Disinfection policy, and Resident Care Equipment policy for accuracy. Re-education for all staff will include review of Cleaning, Disinfection, and Sterilization-Overview policy, Low-Level Disinfection policy and Resident Care Equipment policy. Inventory will be performed to ensure all movable equipment have proper cleaning supplies available. Audit to ensure compliance will include monitoring resident care equipment including vitals towers for cleanliness. Infection Prevention or their designee will be responsible for implementation of workflow. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results.		

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F 880	Continued From page 29 it helps stop the spread of viruses and verified, they had a recent outbreak of COVID. They verified they had not disinfected the vital sign machine between any of the vital signs they took this morning or upon completion of taking vital signs for the morning. During interview with infection preventionist (IP), she stated it is the expectation any equipment used for more than one resident is to be disinfected between residents. She stated all staff have been trained on this on hire, annually and on-going. She stated it is important to disinfect equipment between residents to stop the transmission of disease. During interview with director of nursing (DON) on 12/14/23 at 11:25 a.m., stated it is the expectation all equipment is disinfected between resident, supplies are readily available to staff, education and training is provided to all staff. She stated the importance of disinfecting equipment as it stops transmission of viruses. A facility policy titled, Resident Care Equipment, dated June 2017 was provided. The policy indicates that "each community will protect against indirect transmission, which is the transfer of an infectious agent through a contaminated intermediate object, through decontamination for an object rendering it safe to use". The policy indicates a procedure to follow for disinfecting equipment.	F 880	The Director of Nursing or their designee is responsible for the monitoring of this plan of correction.		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations	F 883			1/17/24

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F 883	Continued From page 30 §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative	F 883			

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F 883	Continued From page 31 has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement the current standards of vaccinations regarding pneumonia for 4 of 5 residents (R13, R17, R31, and R72) over 65 years old whose vaccinations histories were reviewed. Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over 65 years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after 65 years old. R13's facility immunization record, dated 12/12/23, indicated she was 75 years old. The			F 883	Facility has systems in place to ensure pneumonia vaccinations are discussed and offered to residents per current guidelines. Consult with facility Medical Director to discuss 4 identified residents and determine appropriate plan for vaccination. Review of medical record for all residents to determine vaccination status and if shared decision making is appropriate. Facility has reviewed Pneumonia Vaccines for Residents policy for accuracy. CMS guidelines have also been reviewed. Re-education for licensed nurses will include review of policy, current CMS guidelines, and workflow process. Infection Prevention will perform a house audit and define who is due for pneumococcal vaccination. That information will be given to the nurse		

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F 883	Continued From page 32 record indicated she received a PCV13 on 6/4/2013 followed by the PPSV23 on 9/15/2015. A copy of the MIIC (Minnesota Immunization Information Connection) report, provided 12/14/23, indicated PPSV23 was administered 11/1/2009 and 11/20/2009 also. There was no evidence in the electronic medical record or MIIC report that R13 was provided education, offered, or received PCV20 following the PCV13 and PPSV23 series. The record lacked evidence of shared clinical decision making with the physician for PCV20 at least 5 years after the last pneumococcal dose. R17's facility immunization record, dated 12/12/23, indicated she was 97 years old. The record indicated she received a PPSV23 on 10/11/2012 followed by the PCV13 on 3/3/2016. A copy of the MIIC (Minnesota Immunization Information Connection) report, provided 12/14/23, indicated PPSV23 was administered 6/4/1998 and 10/11/2012 also. There was no evidence in the electronic medical record or MIIC report that R17 was provided education, offered, or received PCV20 following the PCV13 and PPSV23 series. The record lacked evidence of shared clinical decision making with the physician for PCV20 at least 5 years after the last pneumococcal dose. R31's facility immunization record, dated 12/12/23, indicated he was 88 years old. The record indicated he received a PPSV23 on 10/7/2014 followed by the PCV13 on 12/8/2016. A copy of the MIIC (Minnesota Immunization Information Connection) report, provided 12/14/23, indicated PPSV23 was administered 9/6/11 and PCV13 on 1/18/17 also. There was no evidence in the electronic medical record or MIIC	F 883	supervisor to have a discussion with resident. If the resident refuses to have the vaccination a provider visit will be made for the resident and provider to discuss. All new admissions will be offered a pneumococcal vaccination and if they decline, an appointment to discuss with provider will be made. Nurse Supervisor will be responsible for implementation of workflow. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. The Director of Nursing or their designee is responsible for the monitoring of this plan of correction.		

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F 883	Continued From page 33 report that R17 was provided education, offered, or received PCV20 following the PCV13 and PPSV23 series. The record lacked evidence of shared clinical decision making with the physician for PCV20 at least 5 years after the last pneumococcal dose. R72's facility immunization record, dated 12/12/23, indicated she was 94 years old. The record indicated she received a PPSV23 on 12/2/2000 followed by the PCV13 on 6/25/15. There was no evidence in the electronic medical record or MIIIC report that R72 was provided education, offered, or received PCV20 following the PCV13 and PPSV23 series. The record lacked evidence of shared clinical decision making with the physician for PCV20 at least 5 years after the last pneumococcal dose. During an interview with infection preventionist (IP), on 12/13/23 at 12:52 p.m., she indicated immunizations are verified upon admission. She indicated immunizations are verified through MIIIC (Minnesota Immunization Information Connection), Epic (electronic health record system) and will ask residents/families and consents are obtained. IP stated she is using the current CDC recommendations from March 2023. IP verified R13, R17, R31 and R72's pneumococcal immunizations as listed above. IP verified they had not been offered or provided education on PCV20. IP stated they have focused on administering influenza immunizations, then COVID immunizations. The next phase is to administer RSV (respiratory syncytial virus) vaccine and then will review pneumococcal vaccines. IP stated they do not have a date or a definite plan in place for administering or hosting an immunization clinic for RSV. At this time, there			F 883			

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F 883	Continued From page 34 is no time frame on when the pneumococcal vaccines will be offered and reviewed. During interview with director of nursing (DON), on 12/14/23 at 1:23 p.m., she indicated IP keeps the records for immunizations and it is everyone's responsibility to ensure residents are up-to date on immunizations. She stated the pharmacist assists with this. She stated they have access to MIRC to help review records. During interview with medical director (MD), on 12/14/23 at 11:32 a.m., she stated flu, COVID and RSV are priority immunizations. She indicated she feels technically residents are up to date on pneumococcal immunizations. She did verify according to the guidelines from CDC, there is a PPSV20 which should be offered. She stated she does not know of any plans, at this time, for administering the RSV vaccine to residents. MD verified she has not had any discussions with any residents regarding the pneumococcal immunizations. A facility policy titled "Pneumococcal Vaccines for Residents" with a review date of 2/7/22 was provided. Policy indicated: it is the policy of BHS communities to provide education and administration of the PPSV23 and PCV13 to the residents of the facility according to CDC recommendations. CDC now recommends pneumococcal conjugate vaccine PCV15 or PVC20 for Adults who have NEVER received a prior pneumococcal conjugate vaccine PCV13 if they are 65 years or older and have certain chronic medical conditions or other risk factors. For adults who have only received PCV13 but not PPSV23, CDC recommends vaccine providers give PPSV23 as previously recommended. One	F 883			

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F 883	Continued From page 35 reference indicated is CDC updated guidance - MMWR 1/28/22.	F 883			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/12/2023. At the time of this survey, ST ANNE EXTENDED CARE was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

01/10/2024

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

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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. SAINT ANNE EXTENDED HEALTHCARE a 6 story building with partial basement. The building was constructed 1962 and was determined to be of Type II (222) construction.	K 000			

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K 000	Continued From page 2 The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 109 beds and had a census of 82 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000			
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain patient sleeping room doors per NFPA 101 (2012 edition), Life Safety Code sections 19.3.6.3, 19.3.6.3.1. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 12/12/2023 between 9:30 AM and 3:30 PM, it was revealed by observation that RM 341 was a split-door assembly having a door-to-door air gap greater than 1/8 inch, allowing free movement of smoke between the corridor and the resident	K 211	Facility has systems in place to ensure full inspection of doors is completed on an annual basis including assessment of any door gaps. Maintenance Door Inspection checklist has been reviewed for accuracy. Education provided for maintenance staff on expectations of work completed during annual door inspections including notification to EVS Director of any issues discovered during inspection.	1/17/24	

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K 211	Continued From page 3 room. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 211	All door inspection documents will be provided to the Director of Environmental Services for review and signature upon completion of door inspection. Issues will be addressed at this time. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction.	1/17/24	
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain, test and inspect the emergency lighting fixtures per NFPA 101 (2012 edition) Life Safety Code, sections 19.2.9.1, 7.9.3 This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 12/12/2023 between 9:30 AM and 3:30 PM, it was revealed during documentation review that the no documentation was present for review that emergency light(s) are being tested. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 291	Facility has systems in place to ensure emergency lighting is tested per guidelines. Documentation of testing results will be maintained in the TELS Preventative Maintenance System. Re-education provided to maintenance staff on frequency and documentation of emergency lighting testing. Results of testing will be provided to Director of Environmental Services for review and entry into TELS. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction.		

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K 293 K 293 SS=D	Continued From page 4 Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly maintain illuminated exit signage per NFPA 101 (2012 edition), section(s) 19.2.10, 7.10, 7.10.1.8. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 12/12/2023 between 9:30 AM and 3:30 PM, it was revealed by observation on the 5th Floor that placement of holiday decorations, hung from the ceiling, visually obstructed exit signage. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 293 K 293	Facility has systems in place to ensure clear visibility of all exit signs at all times. Holiday decorations obstructing view of exits signs were removed on 12/12/2023. Exit sign visibility will be added to safety checklist. Safety Committee will be involved in safety inspections. Results of safety checklist inspections will be provided to Director of Environmental Services for review and signature. Any issues will be immediately addressed and brought forward to Safety Committee for discussion. Re-education provided for all staff include importance of maintaining a clear view of exit signs at all times for emergency and safety purposes. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction.	1/17/24	

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K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.1.1, 4.3, 4.4, 5.2.1.1.2, 13.7. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 12/12/2023 between 9:30 AM and 3:30 PM, it was revealed by observation the on the 5th Floor	K 353	Facility has systems in place to ensure sprinkler heads are free of debris, paint, and spray pattern is not obstructed by any objects. Director of Environmental Services has coordinated vendor to come in and clean sprinkler heads on an annual basis. Holiday decorations obstructing spray pattern were removed on 12/12/2023. Education of Life Safety Code standards will be provided to Maintenance staff related to sprinkler heads maintenance.	1/17/24	

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NAME OF PROVIDER OR SUPPLIER SAINT ANNE EXTENDED HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1347 WEST BROADWAY STREET WINONA, MN 55987		
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K 353	Continued From page 6 in that sprinkler heads were spray pattern obstructed by holiday decorations found hung from the ceiling. 2. On 12/12/2023 between 9:30 AM and 3:30 PM, it was revealed by observation that RM 533 had a sprinkler head exhibited paint coverage. 3. On 12/12/2023 between 9:30 AM and 3:30 PM, it was revealed by observation that in the following locations sprinkler heads exhibited signs of debris loading: 1st Floor- Kitchen; 1st Floor - Dining Room; Ground Level - Break Room. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	Monitoring of this plan will be done by the Safety Committee and results brought back to the committee for discussion. Immediate concerns will be brought to the attention of the Director of Environmental Services and addressed. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction.	1/17/24	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly inspect, and maintain documentation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 6.1.3.8 This deficient finding could have a isolated impact on the residents within the facility. Findings include:	K 355	Facility has systems in place to ensure all portable fire extinguishers are inspected per regulatory guidelines. Walkthrough of facility conducted on 12/12/2023 to ensure all portable fire extinguishers are included on the checklist. Re-education provided for maintenance staff will include importance of inspecting all portable fire extinguishers per regulatory		

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K 355	Continued From page 7 On 12/12/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that on the Ground Floor - Data Room, the fire extinguisher had not inspection dates / staff initials recorded on the annual hangtag for all of 2023. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	guidelines and updating checklist when additional portable fire extinguishers are placed in facility. Results of inspections will be provided to Director of Environmental Services for review, signature and documentation in TELS program. Any issues discovered will be addressed immediately. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction.	1/17/24	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain and inspect smoke / fire dampers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 8.5.5, NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5, 6.5.11. This deficient	K 372	Facility has systems in place to ensure smoke damper test findings are corrected and documented. Vendor onsite 1/04/2024 to determine corrections needed. Parts to correct issue are on order. Once parts have been		

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K 372	Continued From page 8 finding could have a widespread impact on the residents within the facility. Findings include: On 12/12/2023 between 9:30 AM and 1:30 PM, it was revealed by a review of available documentation that no documentation was present to confirm that fire / smoke damper testing findings of the 06/2022 inspection had been addressed or corrected. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 372	received by vendor work will be scheduled. Waiver request has been submitted as work will not be completed by compliance date due to length of time it will take to procure supplies. Maintenance TELS Task has been developed to monitor and provide reminders for inspections to occur every 48 months on facility fire dampers. Re-education provided to EVS staff to follow up on findings and concerns from damper inspection. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction.		
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 374	Facility has systems in place to ensure	1/17/24	

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K 374	Continued From page 9 facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4. These deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 12/12/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that the 3rd Floor smoke barrier door assembly, one of the doors exhibited warpage, as such not self-closing and sealing the opening proerly, allowing for the movement and passage of smoke between smoke compartments. 2. On 12/12/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that the 2nd Floor smoke barrier door assembly, exhibited a door-to-door airgap greater than 1/8 inch, allowing for the movement and passage of smoke between smoke compartments. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 374	full inspection of doors is completed on an annual basis including assessment of any door gaps. Maintenance Door Inspection checklist has been reviewed for accuracy. Education provided for maintenance staff on expectations of work completed during annual door inspections including notification to EVS Director of any issues discovered during inspection. All door inspection documents will be provided to the Director of Environmental Services for review and signature upon completion of door inspection. Issues will be addressed at this time. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction.		
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5.	K 541		1/17/24	

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K 541	Continued From page 10 (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the trash chute safety measures per NFPA 101 (2012 edition), section 19.5.4, 9.5, and NFPA 82 (2009 edition), section 5.2.3.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 12/12/2023 between 9:30 AM and 1:30 PM, it was revealed by observation on the 4th and 3rd Floor in the Utility Rooms that the foot operated trash chute doors were found ajar, not properly sealing the vertical shaft 2. On 12/12/2023 between 9:30 AM and 1:30 PM, it was revealed in the Ground Floor - Trash Cute Room, that the trash chute shaft door safety measure, fusible link, was missing. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 541	Facility has systems in place to ensure trash and laundry chutes are working properly per Life Safety regulations. Vendor contacted on 1/08/2024 to determine replacement parts needed for rubbish chutes. Parts to correct issue are on order. Once parts have been received by vendor, work will be scheduled. Waiver request has been submitted as work will not be completed by compliance date due to length of time it will take to procure supplies. Fusible link on the ground floor trash chute shaft door was replaced on 12/13/2023. Education will be provided for Maintenance staff including inspections of trash and laundry chutes to ensure proper closure, chutes must be fully closed when not in use, inspection notes and any noted issues will be forwarded to Director of		

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K 541	Continued From page 11			K 541	Environmental services for follow up.		1/17/24
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 12/12/2023 between 9:30 AM and 1:30 PM, it was revealed by review of available documentation that no documentation was present to confirm that			K 712	Safety Committee will be responsible for monitoring of this plan and any noted issues will be discussed at Safety Committee meetings. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction. Facility has systems in place to ensure fire drills are conducted per NFPA guidelines for each shift. Facility policy related to conducting fire drills reviewed and found to be appropriate. Facility will utilize a tracking tool to ensure fire drills are held at least quarterly on each shift. Fire drills and results will be documented and included in facility Life Safety Code binder.		

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K 712	Continued From page 12 fire drills were conducted for: 1st Shift in 1st quarter; 2nd shift in 4th quarter; and 3rd shift in 2nd quarter. An interview with Maintenance Director verified these deficient findings at the time of discovery.	K 712	Re-education related to appropriate steps for fire drill, discussion with participants and required documentation is being provided for maintenance staff responsible for conducting fire drills. Director of Environmental Services will review each fire drill report to ensure they are filled out completely and reflect all required documentation. Director of Environmental Services is responsible for monitoring of this plan of correction.		
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the	K 920		1/17/24	

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K 920	Continued From page 13 purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage usage electrical devices in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4, 10.5.2.3 and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 12/12/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that on the 5th Floor in RM 527 that an extension cord was in use. 2. On 12/12/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that on the 3rd Floor in the Common Area that an extension cord was found in use to power Seasonal Decorations. 3. On 12/12/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that on the 1st Floor in the Scheduling Office that power strips were daisy chained together. 4. On 12/12/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that on the 1st Floor in the Copier Room that an appliance was connected to a power strip. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	Facility has systems in place to ensure power strips and extension cords are not used as a substitute for permanent wiring. All inappropriate use of extension cords and power strips was rectified by 1/04/2024. Maintenance Safety Checklist has been developed to monitor for and address possible issues with extension cords / power strip use. Re-education provided for all staff regarding importance of identifying and reporting maintenance related concerns. Monitoring of this plan will be conducted by the Safety Committee and results of monitoring brought to the scheduled meetings. Immediate concerns will be brought to the attention of the Director of Environmental Services. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction.		

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Name of Facility **Saint Anne Extended Healthcare**

2012 LIFE SAFETY CODE

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)

JUSTIFICATION

K372
Based on a review of available documentation and staff interview, the facility failed to maintain and inspect smoke / fire dampers per NFPA 101(2012 edition), Life Safety Code, sections 19.3.7.3, 8.5.5, NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5, 6.5.11. This deficient finding could have a widespread impact on the residents within the facility.

1. A temporary waiver is being requested for K372.
2. No documentation was present to confirm that fire / smoke damper testing findings of the 6/2022 inspection had been addressed or corrected. Access doors for fire dampers located on 5th floor and boiler rooms need to be installed.
3. Vendor was contacted on December 14, 2023 to request work be completed.
4. Vendor provided bid for work which was approved on 1/5/2024.
5. Vendor will not be able to schedule repairs until parts are received. Estimated procurement time is 4 - 6 weeks.
6. Once vendor has received parts, repair will be scheduled immediately.

Requested by  Date 1-9-2024
Executive Director

Surveyor (Signature)	Title	Office	Date
Fire Authority Official (Signature) <i>Travis J. Ahrens 49207</i>	Fire Safety Supervisor	MN State Fire Marshal Div.	1/10/24



Winona Office
374 East Second St.
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La Crosse Office
1202 Caledonia St.
La Crosse, WI 54603
Phone 608.782.6550
www.whvr.com

ESTABLISHED IN 1902

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January 5, 2024

To: Benedictine Living Community
Attn: James Molledahl

Re: Damper Inspection

James, WHV proposes to complete the following work:

Furnish and install access doors for fire dampers located on 5th floor and the boiler room. Inspect dampers and provide updated report.

Adjust ductwork as needed for the laundry return damper. Damper will be tested after adjustment. A new damper will be provided if needed.

We propose to complete this work on a T&M basis not exceeding \$2,244.00.

We can schedule and complete this work upon receipt of the needed access panels.

Please let me know if you have any questions.

Thank you

Kristine Woidyla
WHV, Inc.

Members of: Sheet Metal, Air Conditioning and Roofing Contractors Association of Minnesota
National Roofing Contractors Association | Midwest Roofing Contractors Association

Michael Gostomski, President
An Equal Opportunity Employer

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)

JUSTIFICATION

K541
Based on observation and staff interview, the facility failed to maintain the trash chute safety measures per NFPA 101 (2012 edition),section 19.5.4, 9.5, and NFPA 82 (2009 edition), section 5.2.3.2. These deficient findings could have a widespread impact on the residents within the facility

- 1. A temporary waiver is being requested for K541.
- 2. The rubbish chutes in the utility rooms on both 3rd and 4th floor are not properly sealing the vertical shaft.
- 3. Vendor was contacted on January 3, 2024. Description and picture of parts were provided to vendor to ensure appropriate parts are secured.
- 4. Vendor will not be able to schedule repair of chutes until parts are received. Estimated procurement time is 4 - 6 weeks.
- 5. Once vendor has received parts, repair will be scheduled immediately.
- 6. All trash chutes are equipped with sprinkler system.
- 7. Facility staff have been advised of issue and educated to ensure full closure of rubbish chutes upon use. Signage has also been posted to ensure full closure in the interim.

Requested by Carol Ehlers Date 1-9-2024
Executive Director

Surveyor (Signature)	Title	Office	Date
Fire Authority Official (Signature) <i>Travis J. Ahrens 49207</i>	Title Fire Safety Supervisor	Office MN State Fire Marshal Div.	Date 1/10/24



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 3, 2024

Administrator
Saint Anne Extended Healthcare
1347 West Broadway Street
Winona, MN 55987

Re: State Nursing Home Licensing Orders
Event ID: 43BX11

Dear Administrator:

The above facility was surveyed on December 11, 2023 through December 14, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00955	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/14/2023
NAME OF PROVIDER OR SUPPLIER SAINT ANNE EXTENDED HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1347 WEST BROADWAY STREET WINONA, MN 55987		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/11/23 - 12/14/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

01/10/24

Minnesota Department of Health

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2 000	Continued From page 1 identify the date when they will be completed. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. 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	2 000			

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000			
2 620	MN Rule 4658.0445 Subp. 4 A-N Clinical Record; Admission Information Subp. 4. Admission information. Identification information must be collected and maintained for each resident upon admission and must include, at a minimum: A. the resident's legal name and preferred name; B. previous address; C. social security number; D. gender; E. marital status; F. date and place of birth; G. date and hour of admission; H. advance directives, & Do Not Resuscitate (DNR) & Do Not Intubate (DNI) status, if any; I. name, address, and telephone number of designated relative or significant other, if any; J. name, address, and telephone number of person to be notified in an emergency; legal representative, designated representative, or representative payee, if any; K. legal representative, designated representative, or representative payee, if any; L. religious affiliation, place of worship, and clergy member; M. hospital preference; and N. name of attending physician. This MN Requirement is not met as evidenced	2 620			1/17/24

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2 620	Continued From page 3 by: Based on interview and document review the facility failed to ensure a resident's code status was consistent across the Electronic Medical Record (EMR) and paper chart for one of 10 residents (R46) reviewed for advanced directives. Finding include: R46's Face Sheet, indicated R46 was admitted to the facility on 7/27/21 with a primary diagnosis of hemiplegia and hemiparesis following a cerebral infarction affecting her left, non-dominant, side. The banner at the top of R46's face sheet further indicated R46's code status was do not resuscitate (DNR)/ do not intubate (DNI). R46 physician order, dated 8/5/22, indicted R46's code status was DNR/DNI. R46's Provider Order for Life-Sustaining Treatment (POLST), dated and signed by R46 on 12/13/2019, indicated R46 would like cardiopulmonary resuscitation (CPR) if she had no pulse and/or was not breathing and would like full treatment to include intubation, advanced airway interventions and mechanical ventilation as indicated. R46's Health Care Directive, dated and signed by R46 on 8/30/21, indicated R46 would like CPR attempted if her heart or breathing stopped, based on her current state of health. A Care Conference Progress Note, dated 8/5/22, indicated R46 had changed her mind on her code status and wished to be DNR. During observation 12/12/23 at 2:00 p.m., R46's paper chart behind the nursing station contained	2 620	corrected		

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2 620	Continued From page 4 R46's face sheet as the first page, indicating R46 was DNR/DNI. Directly behind R46's face sheet was R46's Health Care Directive which indicated R46 was full code and would like to be resuscitated. During an interview on 12/12/23 at 2:23 p.m., licensed practical nurse (LPN)-D stated she would use the "Banner" in the EMR to know a resident's code status and stated R46's code status was DNR/DNI. During an interview on 12/12/23 at 3 p.m., nurse manager and registered nurse (RN)-A stated the best place to look for a resident's code status was the "Banner" in the EMR as that was the most accurate information. During an interview on 12/14/23 at 10:40 a.m., nurse manager and RN-A stated they used a checklist to indicate what documents to send with a resident when then needed to go to the hospital. Among those documents to send to the hospital with the resident was the POLST and physician orders. RN-A confirmed these documents for R46 would contain conflicting information with the orders stating DNR and the POLST stating full code. During an interview on 12/14/23 at 12:10 p.m., the director of nursing (DON) stated she would expect the information on code status to match, acknowledging there was conflicting information in R46's chart. A facility policy on code status and advanced care planning was reviewed. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could	2 620			

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2 620	Continued From page 5 develop, review, and/or revise policies and procedures to ensure a process for consistant code status is used. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 620			
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as	21390			1/17/24

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21390	Continued From page 6 disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure communal vital signs machine was disinfected between resident use for 2 of 2 residents (R61, R71) observed to have vital signs checked conducted without proper disinfection of the machine. This practice had the potential to affect all 26 of 26 resident residing on the floor. Findings include: On 12/14/23 at 7:49 a.m., licensed practical nurse (LPN)-A was observed to enter R71's room with the communal vital sign machine. LPN-A proceeded to take vital signs for R71 and exited her room. LPN-A was not observed to disinfect the vital sign machine. There were no disinfecting wipes observed on the vital sign machine. The vital sign machine was left in the hallway, while LPN-A stopped and talked to another staff. On 12/14/23 at 7:51 a.m., LPN-A was observed entering R61's room with the communal vital sign machine that had not been disinfected. LPN-A proceeded to take vital signs for R61. Upon exiting the room, the communal vital sign machine was placed by the nursing station, by the scale without being disinfected. During interview with LPN-A, on 12/14/23 at 8:05 a.m., they stated that they had taken numerous residents vital signs this morning. They stated it is	21390	corrected		

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21390	Continued From page 7 expected to disinfect the vital sign machine between each resident, the importance of this as it helps stop the spread of viruses and verified, they had a recent outbreak of COVID. They verified they had not disinfected the vital sign machine between any of the vital signs they took this morning or upon completion of taking vital signs for the morning. During interview with infection preventionist (IP), she stated it is the expectation any equipment used for more than one resident is to be disinfected between residents. She stated all staff have been trained on this on hire, annually and on-going. She stated it is important to disinfect equipment between residents to stop the transmission of disease. During interview with director of nursing (DON) on 12/14/23 at 11:25 a.m., stated it is the expectation all equipment is disinfected between resident, supplies are readily available to staff, education and training is provided to all staff. She stated the importance of disinfecting equipment as it stops transmission of viruses. A facility policy titled, Resident Care Equipment, dated June 2017 was provided. The policy indicates that "each community will protect against indirect transmission, which is the transfer of an infectious agent through a contaminated intermediate object, through decontamination for an object rendering it safe to use". The policy indicates a procedure to follow for disinfecting equipment. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), ICP, or designee could review facility policies/procedures regarding disinfecting communal equipment between	21390			

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21390	Continued From page 8 residents. They could also do environmental rounds, audits, and re-education anytime isolation precautions are placed. The ICP should have formal training to be completed according to regulation and head the above measures. In additon, the DON or designee should review and ensure compliance with disinfecting of communcal equipement with audits to ensure policies are being followed to ensure on-going competence. The ICP, DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: 21 (twenty-one) DAYS	21390			
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or	21545			1/17/24

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21545	Continued From page 9 safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure they were free of a medication error rate of five percent or greater. The facility had a medication error rate of 6.9 % with two errors out of 30 opportunities for error involving 2 of 6 residents (R73, R61)who were observed during the medication pass. Findings include: R73's annual Minimum Data Set (MDS)	21545	corrected		

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21545	Continued From page 10 assessment dated 10/8/23, identified R73 was severely cognitively impaired and had diagnoses which included cancer, diabetes mellitus, dementia, and depression. R73's Physician Order Report identified R73 had orders as follows: -10/9/23, Humalog insulin 100 units per milliliter (ml) 17 units subcutaneously once a day between 11:00 a.m. and 1:00 p.m. On 12/12/23 at 12:18 p.m., during an observation licensed practical nurse (LPN)-A prepared Humalog insulin for R73 by scrubbing the hub of the pen, placing a disposable needle on the pen and priming the needle by dialing two units and wasting the insulin. LPN-A then dialed up 17 units of insulin and proceeded to R73's room. -at 12:22 p.m., LPN-A was stopped and asked about the open date for the insulin pen. LPN-A looked at the pen again and was unable to locate an open date. LPN-A said insulin was good for 28 days after opening and because she could not locate an open date she should not give the insulin she prepared and should discard the pen and get a new pen. LPN-A then removed a new insulin pen for R73 and scrubbed the hub, wasted two units of insulin and dialed up 17 units of insulin and then proceeded to R73's room and administered the insulin from the new pen. On 12/12/23 at 12:30 p.m., during an interview LPN-A stated the importance of dating insulin pens was to ensure the insulin was not used past 28 days to ensure the insulin would still be effective. R61's quarterly MDS assessment dated 10/3/23,	21545			

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21545	Continued From page 11 indicated R61 was cognitively intact and had diagnoses which included cerebrovascular accident (stroke), hypertension, and hemiplegia and hemiparesis (loss of strength or paralysis on one side of the body). R61's Physician Order Report identified R61 had orders as follows: -5/31/23, refresh relieva one drop ophthalmic eye twice a day morning and bedtime med pass On 12/13/23 at 8:26 a.m., during an observation trained medication aide (TMA)-A was preparing medications for R61. TMA-A picked up a bottle of refresh tears with an open date of 10/23/23, and an expiration date of 3/2026. TMA-A stated she was not sure if the eye drops were for both eyes or just one eye. TMA-A asked LPN-A what to do and was told to place one drop in both eyes. TMA-A had R61 tip their head back and placed a drop in each eye. On 12/14/23 at 9:26 a.m. the consultant pharmacist (CP) stated the staff should have checked the order for clarification and if the details were missing they should have held the eye drops until they received that clarification. On 12/14/23 at 10:49 a.m., the director of nursing (DON) stated if an insulin pen was not dated the staff should have done one of two things. One would be to throw the insulin pen away, the second would be to check the send date from the pharmacy and if it was within the 28 days the pen could be dated as opened on the send date and use the pen up to the 28 days. In addition, the DON stated if the route for eye drops was not specified in the order (for example right eye, left eye, or both eyes) the staff should not administer	21545			

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21545	Continued From page 12 the eye drops until the order was clarified. Preparation and General Guidelines dated 4/1/19 Medication Administration directed staff to follow the five rights of medication administration, right resident, right drug, right dose, right route, and right time. In addition, the policy directed staff to check the medications for the five rights at 3 steps in the process: when they selected the medication, when the medication was removed from the container and again after the dose was prepared and the medication was being being put away. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure staff were trained/re-trained on preventing medication errors (i.e. the five rights of medication administration). The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545			
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services.	21550			1/17/24

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21550	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure narcotics were counted in a manner to detect potential diversion at shift change for 2 of 7 medication carts reviewed. Findings include: On 12/12/23 at 2:50 p.m., licensed practical nurse (LPN)-B on-coming staff and LPN-C off-going staff counted narcotics in two carts. LPN-B unlocked the drawer and would call out the group number and the page number. LPN-C would look for the page number in the narcotic book and LPN-B would say how many pills or milliliters (ml) if it was a bottle with liquid. LPN-C would confirm the number or ml was correct. The index page and/or paging through each page was not used to ensure all medications were accounted for. LPN-B stated the on-coming staff was in the drawer and the off-going staff was looking in the book. On 12/12/23 at 2:58 p.m., LPN-B stated unless they looked at each page in the book they would not know if a card or bottle was missing. LPN-B verified they did not review each page and not all medications had been signed into the index page of the narcotic book. On 12/12/23 at 3:02 p.m., registered nurse (RN)-A stated the process was to use the index page to sign in all narcotics. In addition, RN-A stated staff needed to use the index page to count narcotics at shift change would to ensure all medications were accounted for. RN-A verified the index pages had medications not signed into the book, three of 40 were not signed into book	21550	corrected		

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21550	Continued From page 14 one, seven of 40 were not signed into book two, two of 40 were not signed into book four, and four of 12 were not signed into book five. On 12/12/23 at 3:15 p.m., RN-B stated the process for the narcotic count would be to check each page to ensure all medications were accounted for and correct. RN-B stated staff should be signing all narcotics into the book using the index page and filling out the information on the corresponding page. On 12/12/23 at 3:21 p.m., the assistant director of nursing (ADON) verified the books had missing entries for narcotics on the index pages of the narcotic books. The ADON verified when staff complete the narcotic count at shift change they should be counting from the book (checking each page) to ensure each medication is accounted for. On 12/12/23 at 3:34 p.m., the director of nursing (DON) verified it was best practice to sign each narcotic into the index page and fill in the information on the corresponding page. The DON verified staff should look at each page to ensure all narcotics were counted and accounted for to prevent diversion. On 12/14/23 at 9:31 a.m., the consultant pharmacist (CP) verified staff should count narcotics from the book to ensure no medications were missing from the cart. Medication Ordering And Receiving From Pharmacy dated 4/1/19, directed staff to do the following: "Controlled substance inventory sheets are completed, if necessary , and filed appropriately.	21550			

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21550	Continued From page 15 A hard-bound log book is utilized to track the controlled substance from delivery to disposition. " SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure staff were trained/re-trained on signing in narcotics and the procedure for counting narcotics. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21550			
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were labeled appropriately with open dates. In addition, the facility failed to remove expired medications for 6 of 82 residents (R76, R29, R34, R16, R39) whose medications were observed during medication storage. Findings include: During the medication storage tour on the second	21620	corrected		1/17/24

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21620	Continued From page 16 floor on 12/13/23 at 2:11 p.m., with trained medication aide (TMA)-B there were medications with no open dates and medications/items past the expiration date as listed below: -lantus insulin for R29 with no open date -29 hydrogen peroxide wipes manufacturer's expiration date of 11/9/22 -copper tone sun screen with manufacturer's expiration date of 11/2020 -equate sport sun screen with manufacturer's expiration date of 11/2020 -mineral oil with manufacturer's expiration date of 12/5/22 On 12/13/22 at 2:15 p.m., registered nurse (RN)-A stated medication carts should be checked monthly for expired medications. RN-A stated this was important to ensure residents did not receive medications which had expired. During the medication storage tour on the third floor on 12/13/23 at 2:34 p.m., with licensed practical nurse (LPN)-A antacid tablets with manufacturer's expiration date of 9/2023 were found in the medication cart. During the medication storage tour on the fifth floor on 12/14/23 at 10:06 a.m., with LPN-E there were medications with no open dates and medications/items past the expiration date listed below: - albuterol inhaler for R34 expiration date of 10/2022 -aspirin 81 milligrams (mg) expiration date of 1/2023 -glycerin eye drops for R16 expiration date of 7/2023 -naphocon-a-sol eye drops for R16 expiration	21620			

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21620	Continued From page 17 date of 9/15/22 -albuterol inhaler for R39 expiration date of 9/18/23 On 12/14/23 at approximately 10:15 a.m., LPN-E stated it was important to have a process in place to make sure staff were not administering expired medications to residents. During the medication storage tour on the fourth floor on 12/14/23 at 10:27 a.m., with LPN-D dorzolamide timolol eye drops for R76 were found with an expiration date of 7/2023. On 12/14/23 at 9:29 a.m., consultant pharmacist (CP) stated staff should be checking medications in the carts on a regular basis to ensure there were no outdated medications. On 12/14/23 at 10:53 a.m., the director of nursing (DON) stated the staff should be completing cart audits monthly. The DON stated the purpose was to ensure residents were not given outdated medications as they could have lost their effectiveness. Medication Storage in the Facility dated 4/1/19, included-directed the staff to do the following: "E. The nurse will check the expiration date before administering it. F. No expired medication will be administered to a resident. G. All expired medications will be removed from the active supply and be destroyed in the facility, regardless of the amount remaining. The medication will be destroyed in the usual manner." SUGGESTED METHOD OF CORRECTION:	21620			

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21620	Continued From page 18 The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure medications were labeled with open dates and medication carts were checked for outdated/expired medications. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21620			