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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

ID: HFGP

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY**

Facility ID: 00955

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245233**
2.STATE VENDOR OR MEDICAID NO.
(L2) **633543800**

3. NAME AND ADDRESS OF FACILITY
(L3) **SAINT ANNE EXTENDED HEALTHCARE**
(L4) **1347 WEST BROADWAY**
(L5) **WINONA, MN** (L6) **55987**

4. TYPE OF ACTION: **7** (L8)
**1. Initial** **2. Recertification**
**3. Termination** **4. CHOW**
**5. Validation** **6. Complaint**
**7. On-Site Visit** **9. Other**
**8. Full Survey After Complaint**

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/14/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

| | | | | |
|---|---|---|---|---|
| **01 Hospital** | **05 HHA** | **09 ESRD** | **13 PTIP** | **22 CLIA** |
| **02 SNF/NF/Dual** | **06 PRTF** | **10 NF** | **14 CORF** | |
| **03 SNF/NF/Distinct** | **07 X-Ray** | **11 ICF/IID** | **15 ASC** | |
| **04 SNF** | **08 OPT/SP** | **12 RHC** | **16 HOSPICE** | |

FISCAL YEAR ENDING DATE: (L35)
**09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **109** (L18)
13.Total Certified Beds **109** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 109 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Supervisor 09/14/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske - Downing, L & C Program Representative 09/28/2018 (L20)

**PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY**

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
**08/01/1983**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**03001**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
CMS Certification Number (CCN): 245233

September 18, 2018

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 4, 2018 the above facility is certified for:

109 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 109 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered

September 18, 2018

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

RE: Project Number S5233028

Dear Administrator:

On August 13, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 26, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 14, 2018, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 7, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 26, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 4, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 26, 2018, effective September 4, 2018 and therefore remedies outlined in our letter to you dated August 13, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

ID: HFGP

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY**

Facility ID: 00955

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245233**
2.STATE VENDOR OR MEDICAID NO.
(L2) **633543800**

3. NAME AND ADDRESS OF FACILITY
(L3) **SAINT ANNE EXTENDED HEALTHCARE**
(L4) **1347 WEST BROADWAY**
(L5) **WINONA, MN** (L6) **55987**

4. TYPE OF ACTION: **2** (L8)
**1. Initial** **2. Recertification**
**3. Termination** **4. CHOW**
**5. Validation** **6. Complaint**
**7. On-Site Visit** **9. Other**
**8. Full Survey After Complaint**

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/26/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

| | | | | |
|---|---|---|---|---|
| **01 Hospital** | **05 HHA** | **09 ESRD** | **13 PTIP** | **22 CLIA** |
| **02 SNF/NF/Dual** | **06 PRTF** | **10 NF** | **14 CORF** | |
| **03 SNF/NF/Distinct** | **07 X-Ray** | **11 ICF/IID** | **15 ASC** | |
| **04 SNF** | **08 OPT/SP** | **12 RHC** | **16 HOSPICE** | |

FISCAL YEAR ENDING DATE: (L35)
**09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **109** (L18)
13.Total Certified Beds **109** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
**X** B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 109 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Stephanie Powers, HFE NE II 08/27/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
09/08/2018 (L20)

**PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY**

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
**08/01/1983**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**03001**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
August 13, 2018

Ms. Jodi Barton, Administrator
Saint Anne Extended Healthcare
1347 West Broadway
Winona, MN 55987

RE: Project Number S5233028

Dear Ms. Barton:

On July 26, 2018, a standard survey was completed at your facility by the Minnesota Departments 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

## DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

## OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 4, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 4, 2018 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

## ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

### Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

### Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

### Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by October 26, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 January 26, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

## INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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<br><br>A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on July 23, 24, 25 & 26, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>On July 23, 24, 25, & 26, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.<br><br>The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form.<br><br>Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 550 SS=E | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident | F 550 | | 9/4/18 |

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

Electronically Signed | 08/23/2018

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SAINT ANNE EXTENDED HEALTHCARE** | **1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 550 | Continued From page 1<br>with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure a dignified dining experience for 7 of 7 residents (R25, R45, R55, R39, R1, R5 and R85) identified, who received meals on a secured dementia unit and failed to treat 1 of 1 resident (R31) in a dignified | F 550 | Facility has systems in place to support resident's right to choose activities, schedules, healthcare and providers of health care services consistent with his or her interests, assessments and plan of care. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 550 | Continued From page 2<br>manner during dressing assistance for a dependent resident reviewed for dignity.<br><br>Findings include:<br><br>DIGNIFIED DINING EXPERIENCE:<br><br>During lunch meal observation on the fifth floor (a secured unit) on 7/25/18, at 12:18 p.m., 12 residents were eating at the dining room tables and were observed to be served all of their meal items on brown trays placed on the dining room tables (dishes were not placed directly on the table and the trays were not removed).<br><br>During breakfast meal observation on 7/26/18, at 9:00 a.m., on the fifth floor R25, R45, R55, R39, R1, R5 and R85 sat at dining room tables and had brown trays sitting in front of them (dishes were not placed directly on the table and the trays were not removed). R25, R45, R55, R39, R1, R5 and R85 were asked about meal trays left on table and they were not found not to be interviewable.<br><br>According to the facility Resident Face Sheets, dated 7/26/18, R25's diagnoses included Alzheimer's dementia. R45's diagnoses included unspecified dementia without behavioral disturbance. R55's diagnoses included unspecified dementia with behavioral disturbance. R39's diagnoses included Alzheimer's dementia. R1's diagnoses included unspecified dementia without behavioral disturbance. R5's diagnoses included dementia with Lewy bodies. R85's diagnoses included unspecified dementia without behavioral disturbance. | F 550 | Facility reviewed and revised policies as necessary. Policy related to nursing responsibilities during meal delivery is being updated. Dignity and Respect of Each Resident policy was reviewed and found to be appropriate.<br><br>A customer concern was filed on behalf of R31 on 7/26/18 when staff were notified of the concern. Concern was investigated and resolved to resident's satisfaction.<br><br>The Daily Review of Care Plan form will be updated to reflect any changes with resident dining preferences. CNA Care Sheets will be updated to reflect any necessary changes. Facility will revise Care Conference agenda to reflect questions intended to facilitate discussion about possible changes in resident preferences in regards to dining.<br><br>Facility will provide re-education for all staff regarding residents' rights to participate in decisions on clothing and dining preferences.<br><br>Facility will provide re-education for nursing staff related to their responsibilities before and during meals.<br><br>Meal service audits will be conducted weekly through 10/31/18.<br><br>Director of Nursing or their designee is responsible for monitoring of this plan of correction. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 550 | Continued From page 3 | F 550 | | |

During interview on 7/26/18, at 2:42 p.m., when queried why dishes containing food items were not removed from the trays and placed directly on the table in front of the residents during meals on the fifth floor, the director of nursing (DON) stated I do not have an answer for that questions. DON said that I never thought about it. DON stated I think we do the same on the other floors (floors 2, 3, and 4). The DON confirmed residents who ate in the main dining room located on the first floor did not have trays placed on the tables and all items for the meals were placed directly on the dining room tables. DON stated I agree it is not a dignified dining experience for the residents (regarding the leaving of food dishes on the tray while eating).

The Dignified Dining Experience policy, dated revised 3/6/17, indicated purpose: dignified dining experience will be given to all residents no matter where they choose to dine.
DIGNIFIED TREATMENT WHEN CHOOSING CLOTHING:

R31's Face Sheet, printed 7/26/18, revealed diagnoses of depression, anxiety, and muscle weakness.

R31's 5 day, prospective payment system (PPS), Minimum Data Set (MDS), dated 6/20/18, identified R31 to need extensive assist of one person with dressing.

R31's care plan edited 7/23/18 identified a problem of self-care deficit related to impaired ability to perform activities of daily living (ADLs) for oneself. Goal: will be neat, clean, and appropriately dressed daily by next review. Approach: assist of 1 with grooming needs,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SAINT ANNE EXTENDED HEALTHCARE** | **1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 550 | Continued From page 4 | F 550 | | |

including picking out clothing, picking out jewelry. Helping change clothes and get ready for the day or bed.

During observation and interview on 7/24/18, at 11:20 a.m. R31 was sitting on the edge of her bed well dressed and groomed. R31 stated, "Nursing assistant [NA-A] came in my room either yesterday or the day before to help me get dressed and get down to breakfast. I told [NA-A] something she didn't like, she tells me to get up, put this and that on. I didn't like what I was going to wear, so I took it off, and she yelled at me and told me to put it back on." "I felt not very important at all, like I was an item or something, she isn't always like that, but she is bossy and it makes me feel like a little kid." R31 further stated, every morning I hear someone coming, I am always hoping it's someone else, but it's always NA-A. I probably don't have as much patience as I used to. I am sure I am aggravating to them the way I am. NA-A doesn't ask what I want to wear. I usually have something there hanging, and "I guess she assumes that's what I want to wear."

During observation and interview on 7/25/18, at 11:09 a.m. R31 was well dressed and groomed walking with her wheeled walker in her room. R31 stated, "I got to wear the clothes I wanted today and the staff this morning treated me with dignity and respect."

During interview on 7/26/18, at 2:06 p.m. R31 stated she did not feel like she was being abused. "I just want to be able to wear what outfit that I want to wear, without feeling bossed."

During interview on 7/26/18, at 2:32 p.m. social

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 550 | Continued From page 5<br>service (SS)-A verified R31's cognition was intact. SS-A stated she was not aware of the situation and stated she would definitely start investigating this concern. My expectation would be that residents should always be treated with respect and dignity. "Our whole practice is to treat people with respect, this is their home and to give them choices."<br><br>During interview on 7/26/18, at 3:23 p.m. director of nursing (DON) stated, "Our residents will be treated with respect and dignity, our staff will be respective to residents, while providing cares." I have zero tolerance for how our residents are treated, should always be with respect and dignity.<br><br>The Dignity and Respect of Each Resident policy reviewed 8/10/15, included dignity is defined as the maintenance of a resident's self-esteem and self-worth. Saint Anne of Winona expects each employee to treat each and every resident with dignity and respect to maintain self-esteem and self-worth for all residents. | F 550 | | |
| F 561 SS=D | Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.<br><br>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, | F 561 | | 9/4/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 561 | Continued From page 6<br>assessments, and plan of care and other applicable provisions of this part.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure preference for waking times was granted for 1 of 1 resident (R81) reviewed for choices.<br><br>Findings include:<br><br>R81's face sheet indicated that R81 admitted on 1/18/02 and included diagnoses of cerebrovascular disease, spastic hemiplegia affecting dominant right side, muscle weakness and anxiety disorder.<br><br>R81's care plan indicated R82 liked to be up before 8 a.m. and breakfast was served from 7:30 a.m. to 9:00 a.m.<br><br>R81 was observed on 7/26/18 from 7:14 a.m. to 8:17 a.m. and revealed the following:<br>-7:14 a.m. upon surveyor entering 3rd floor, R81's | F 561 | Facility has systems in place to promote and support residents' rights to choice of activities and schedules (including sleeping and waking times).<br><br>Facility policy related to resident rights, notification of resident rights, and resident participation in care planning was reviewed and found to be appropriate.<br><br>Review of R81 care plan indicates resident prefers to get up in the morning before 8am. R81 care plan and CNA care sheet reflects residents' current preference.<br><br>DON will review morning hour staffing patterns to identify possible changes that could be made to more readily accommodate individual resident rising | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 561 | Continued From page 7<br>call light was observed to be on.<br>-7:16 a.m. overheard through walkie-talkie that staff carry, "306 third request". A nursing assistant came out another room and a trained mediation aide was at medication cart.<br>-7:25 a.m. R81's call light was still on.<br>-7:27 a.m. R81's call light was still on. No staff have entered or gone by R81's room.<br>-7:36 a.m. R81's call light was still on<br>-7:39 a.m. licensed practical nurse-(LPN)-B, entered R81's room and turned off the call light. When LPN-B came back out of room stated; "R81 would like to get up. I'm going to see who has R81. Mornings are rough and R81 is one that does not like to wait for very long."<br>-8:02 a.m. R81 was still in bed, according to call light marque in hallway R81's call light was not on at this time.<br>-8:17 a. m. R81 was looking out door, writer knocked on door and observed the call light was on again at bedside. R81 stated that staff came in earlier and told her they were, "working on getting her up." R81 stated she had her call light on at seven so that she can be up by eight and stated, "I'm still not up. Then they wonder why the bed is wet in the morning." R81 stated she turned the call light back on about fifteen minutes after they had turned it off.<br>-8:22 a.m. nursing assistant (NA)-E verified that call light was not showing on the marque in the hallway and the call light was on at bedside call box. NA-E was unable to state whether the call came over on walkie-talkies as batteries had died and she had not replaced them yet. R81 then told NA-E that she had be waiting to get up for over an hour. NA-E assisted R81 with shoes, transferred her into wheelchair and then into bathroom. NA-E stated R81 had been incontinent. NA-E stated R81 was incontinent at | F 561 | time preferences.<br><br>Weekly audits will be conducted to monitor resident satisfaction with efforts to support rising time preferences through 10/31/18.<br><br>Facility will provide re-education for all staff regarding residents' rights to participate in decisions and develop plans related to their care and treatment.<br><br>Director of Nursing or their designee are responsible for monitoring of this plan of correction. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 561 | Continued From page 8 | F 561 | | |

times in the morning, but during the day was usually continent. NA-E stated, "I know R81 likes to be up early, because she smokes. I am surprised someone has not come in here and asked her if she was ready to get up yet."

During an interview on 7/26/18, at 11:05 a.m. R81 stated, "I keep getting up later and later, they tell me they are coming but they never do. So sick of that [curse word]."

During an interview on 7/26/18, at 11:10 a.m. nursing assistant (NA)-D stated, "I start at 5:30 a.m. and when I come I start with the group there are people on that like to get up early. Then work with getting people with appointments up and those that go downstairs for breakfast. I will try to answer the call lights but once you are in a room doing cares you cannot leave that resident. NA-D stated the trained medication aides (TMA) and nurses are good about answering call lights when they have time, but we know they are busy too. I feel that I can get my work completed, I know mornings are a struggle but we try and time management is a key."

During an interview on 7/26/18, at 11:15 a.m. nursing assistant (NA)-C stated R81 was in her group today and that it was her second day on this unit. NA-C stated she had asked nurse how to start her day and the nurse explained that another resident liked to get in early, and then I went to do a shower before breakfast. I had completed cares for the first resident and was in process starting the shower for another resident when I realized that R81 call light was on. "Yes, I knew that it was on for an extended period of time, but I had already start getting the resident ready for shower. The only time it really get hectic

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 561 | Continued From page 9<br>is in the morning is when we are trying to get people up for the day, all the call lights are going, we will answer lights for each other, but we have our own groups."<br><br>During an interview on 7/26/18, at 3:28 p.m., the director of nursing (DON) stated that were about fifteen people that like to get up early on third floor. I would need to hire eight more staff to accommodate everyone's personal preferences, that won't happen. Review of call log for R81 revealed that most call light response times with long wait times of greater that twenty minutes, were in the morning. The DON stated that she would have the nurse manager on third floor look at the assignment sheet for the aide to see if they are able to rearrange to ensure R81's preference of wake time was managed.<br><br>Dignity and Respect of Each Resident policy dated May 17, 2006, included, "Let the resident make choices."<br><br>Residents Rights and Notification of Resident Rights undated policy included,<br>Self-determination. The resident Bill of Rights states: The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to: The right to choose sleeping and waking times. | F 561 | | |
| F 565 SS=E | Resident/Family Group and Response<br>CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)<br><br>§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.<br>(i) The facility must provide a resident or family group, if one exists, with private space; and take | F 565 | | 9/4/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 565 | Continued From page 10<br>reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.<br>(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.<br>(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.<br>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.<br>(A) The facility must be able to demonstrate their response and rationale for such response.<br>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.<br><br>§483.10(f)(6) The resident has a right to participate in family groups.<br><br>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to promptly act upon grievances raised at the resident council meetings. There were nine residents who attended the meeting with the state surveyors with 4 of 9 residents (R48, R26, R81, & R6) voicing concerns. In addition, the staff supporting the resident council | F 565 | Facility supports resident right to organize and participate in resident groups in the facility.<br><br>Facility policy related to Resident Council was reviewed and is being updated to reflect new approaches. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 565 | Continued From page 11<br>failed to write minutes that fully reflect the meeting content and failed to provide the minutes for residents for review.<br><br>Findings include:<br><br>On 7/24/18, at 7:30 a.m., an active member of the resident council (R48) gave permission for the survey team to review previous minutes of resident council meetings. These minutes were provided and reviewed.<br><br>The meeting minutes dated 4/17/18 identified 14 people in attendance. First names only were listed with no distinction between staff and residents. The minutes did not reflect review of resident rights or resident choice to not have staff present. The minutes indicated R26 was still missing her pants.<br><br>The meeting minutes dated 5/29/18 identified 5 people in attendance. First names only were listed with no distinction between staff and residents. The minutes did not reflect review of resident rights or resident choice to not have staff present. The minutes indicated R26 was still missing her pants. No new business or department review notes were evident.<br><br>The meeting minutes dated 6/17/18 identified 14 people in attendance. First names only were listed with no distinction between staff and residents. The minutes do not reflect review of resident rights or resident choice to not have staff present. The minutes reflected R26 was still missing her pants. The June minutes identified some concerns about the nursing department: -"one nurse does it one way and others do it another way. Not enough aides. Need more help. | F 565 | Follow up to concerns outlined in survey findings will be provided for residents at next Resident Council meeting. Moving forward, Resident Council agenda and meeting minutes will:<br><br>1) Reflect first and last names of all in attendance. 2) Reflect a distinction between staff and residents in attendance. 3) Include a review of residents' rights and right to not have staff present. 4) Include a list of concerns and suggestions brought forth at previous meeting. 5) Include review of specific action taken in response to concerns and suggestions brought up at previous meeting. 6) Fully reflect meeting content.<br><br>Minutes will be available for review by residents in attendance at Resident Council meetings. Facility will also post information about availability of meeting minutes for all Residents.<br><br>Administrator will conduct review of next three Resident Council meeting minutes to ensure compliance.<br><br>Director of Nursing or their designee is responsible for monitoring of this plan of correction. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 565 | Continued From page 12 | F 565 | | |

Nurses need more training on their jobs."
-"they are over worked-always busy".

The June minutes also indicated:
--Interest in getting a new shade "out front" and staff were asked to look into prices. The minutes indicated willingness to do a fundraiser if needed.
--A concern that breakfast always comes at a different time; sometimes an hour difference. Residents stated they would like more of a consistent time.
--A concern that certain residents always get serviced first in the dining room.

The meeting minutes dated 7/17/18, indicated 9 residents were in attendance. The minutes separated staff from residents in attendance, but did not have any last names. The minutes lacked any identified action or follow-up to the resident council's previous nursing and culinary department concerns or the potential purchase of a new shade.

On 7/25/18, at 2:00 p.m., a meeting was held with 9 council members in attendance. R81 stated there were a staffing problem; she had to wait an hour and a half to get up today. Someone came in and turned off her call light and then left again. R81 stated staff turned her light off 3 times, and got her out of bed an hour and a half after she first put on her call light. R81 said they were short staffed all the time; when residents bring it up all they would hear was, "we'll take care of it", but they never do. R26 stated she got up 4 hours later than she wanted to today. R6 stated her call light also gets turned off often and she would be told, "oh, it's not time to get up yet, you've got to go back to bed." R6 stated she has to wait up to 45 minutes to get her food and R26 stated she

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 565 | Continued From page 13 | F 565 | | |

thinks they need more help in the dining room.

On 7/25/18, at 3:15 p.m., the activity director (AD) stated she had been running the resident council since March of 2018. The AD stated she would follow-up resident concerns in a couple of different ways: talk to a department head directly, do an E-Source note, use the Matrix program or a "database thing". When asked if a concern raised about missing pants had been resolved (April, May and June minutes), the AD stated they do not have a replacement policy, the pants had been looked for and not found. The AD further stated she had not done a formal complaint on the pants, nor did she know if the resident had received a written response from the facility The AD further stated that minutes were kept in a binder in the activity department. They had not been posted or provided to residents for review. They were read to attendees at the next meeting, but not otherwise provided to residents.

On 7/25/18, at 3:47 p.m., the facility social worker (SW) stated she had run the resident council meetings prior to March 2018. The SW stated she would enter concerns brought up at resident council meetings into a customer concern database. The concern would assigned to someone and leadership could track progress and completion of complaints. The SW stated she had not posted or otherwise provided minutes to residents. The SW stated residents hadn't voiced that they wanted them posted or that they wanted copies, so she hadn't. The SW stated she reviewed a couple of rights each month and gave residents the choice of having her and her staff in the room, but her meeting minutes didn't reflect that.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 565 | Continued From page 14 | F 565 | | |

On 7/26/18, at 7:16 a.m., the AD stated she was not at the June meeting, and did not read through the minutes or ensure follow-up of concerns raised at the June resident council meeting. The AD verified she did not have written evidence of follow-up of concerns raised at resident council meetings since she took over in March 2018. The AD stated she had been requesting some follow-up through Matrix, but not using the customer concern database. The AD also stated she had not been aware of the regulations and requirements related to follow-up of grievances and concerns raised at resident council meetings. The AD stated the minutes were not specific and did not fully reflect the content of meetings.

Resident council actions forms from March 2018 through July 2018, were requested but not received from the facility. Written documentation of resident council concerns was requested but not received from the facility.

The Resident/Family Concern Policy/Service Recovery Program policy dated 9/1/17, indicated, the goal was for concerns and issues to be resolved within 5 business days and documentation of action would occur.

The Resident Council policy dated 2017, indicated minutes are to be maintained for meetings and are provided, or accessible to residents. The policy further directs the facility demonstrate follow-through on written requests/concerns voiced by the Resident Council. The policy also indicated the facility would listen to resident group views, and act upon the concerns and recommendations of residents and that the facility would communicate it's decisions to the resident group.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 577 SS=C | Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11)<br><br>§483.10(g)(10) The resident has the right to-<br>(i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and<br>(ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.<br><br>§483.10(g)(11) The facility must--<br>(i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.<br>(ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and<br>(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.<br>(iv) The facility shall not make available identifying information about complainants or residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to post a notice indicating the last 3 years of survey results would be made available upon request. This had the potential to affect all 101 residents residing in the facility.<br><br>Findings include:<br><br>On 7/25/18, at 4:06 p.m., the facility's most recent year of survey results was observed in a binder | F 577 | Facility posts results of most recent survey in a place readily accessible to residents, family members and legal representatives of residents.<br><br>Reports with respect to any surveys, certifications and complaint investigations made with respect to the facility during the 3 preceding years, and any plan of correction in effect with respect to the | 9/4/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 577 | Continued From page 16<br>on the front reception desk. There was no posted information indicating any other results were available, and there was no indication in the binder that the last three years of results were available.<br><br>On 7/25/18, at 4:10 p.m., the administrator stated she did not see indication of availability of the last three years of survey results, but she would "have to look and see."<br><br>On 7/26/18, at 8:39 a.m., the administrator stated the admission packet included the Combined Federal and State Bill of Rights, and on page 15, it included, "11. The facility must-B. Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and C. Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public." The administrator confirmed this was the only notification that the preceding years survey results were available. | F 577 | facility are also available for any individual to review upon request.<br><br>Facility has added a posting regarding availability of such reports in area prominent and accessible to the public near the front entrance of the facility.<br><br>Administrator or their designee is responsible for monitoring of this plan of correction. | |
| F 584 SS=E | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to | F 584 | | 9/4/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 584 | Continued From page 17<br>use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure hot water for 3 of 5 residents (R95, R65 and R36); failed to ensure a door was maintained in working order for 1 of 1 resident (R94) and failed to ensure a clean wheelchair cushion for 1 of 1 resident (R30) reviewed for environment. | F 584 | Facility has systems in place to ensure a safe, clean, comfortable and homelike environment.<br><br>Facility policy related to wheelchair washing has been reviewed and is being updated to reflect new approaches. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 584 | Continued From page 18<br><br>Findings include:<br><br>LACK OF HOT WATER:<br><br>During observation on 7/23/18, at 3:46 p.m., R95's hot water in R95's bathroom was cool to touch.<br><br>During observation and interview on 7/23/18, at 4:01 p.m., surveyor checked R65's hot water in R65's bathroom. The hot water was cool to touch. R65 stated the nursing assistants told me some rooms are cool. My water is not hot. It is cool.<br><br>During observation on 7/24/18, at 1:50 p.m., R36's hot water in R36's bathroom was cool to touch.<br><br>During observation on 7/26/18, at 3:31 p.m., the environmental services director (ESD)-D turned on the hot water in R95, R65 and R36's bathroom, held his hand under the water while it was running and stated the water was not hot. ESD-D stated we do not check the temperature of hot water in the resident rooms. We check the hot water temperature only off the water heaters.<br><br>On 7/26/18, at 3:59 p.m., ESD-D stated he had not received notification of the hot water being cool in R95, R65 and R36's bathrooms.<br><br>On 7/26/18, at 4:55 p.m., ESD-D stated he expected water temperatures to be around 105 to 115 degrees Fahrenheit. ESD-D stated the facility had no policy regarding the water temperatures.<br><br>DOOR HARD TO OPEN: | F 584 | Facility will establish a policy and procedure for regular monitoring of water temperatures.<br><br>R94 room door has been planed to ensure ease of opening and closing.<br><br>R30 wheelchair pad has been cleaned. R30 care plan and CNA care sheets updated to reflect need for wiping down wheelchair and cushion after each meal TID.<br><br>Director of Maintenance will involve outside contractor to assist with remedy for low water temperatures in R95, R65 and R36 rooms.<br><br>Re-education provided at All Staff Meetings held on 8/7/18 and 8/8/18 related to importance of reporting resident concerns including maintenance concerns. Additional education will be provided for nursing and maintenance staff related to cleanliness of wheelchairs and water temperature monitoring.<br><br>Director of Environmental Services and Director of Nursing or their designees are responsible for monitoring of this plan of correction. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 584 | Continued From page 19 | F 584 | | |

During observation on 7/24/18, at 10:20 a.m., an unidentified nursing assistant was trying to enter R94's room and the door was hard to open. R94's spouse was present and stated to the nursing assistant (while they were both looking at the door) the door sticks and was hard to open. The unidentified nursing assistant agreed with R94's spouse the door was hard to open.

During observation on 7/26/18, at 3:33 p.m., ESD-D opened and closed R94's room door and confirmed the door was sticking.

On 7/26/18, at 3:59 p.m., ESD-D stated he had not received a slip (notification) R94's room door had been sticking.

During interview on 7/26/18, at 3:26 p.m., ESD-D stated the maintenance department was able to check for reports of environmental concerns/repairs through the facility computer system or telephone. After the concern was addressed, staff would document what had been done in order to close out the concern.

SOILED WHEELCHAIR PAD:

On 7/23/18, at 7:15 p.m., a side support cushion on the right side of R30's wheelchair was observed to be soiled with debris. The cushion had cloth material. On 7/24/18, at 9:42 a.m., the cushion remained soiled with debris.

During observation on 7/26/18, at 10:02 a.m., licensed practical nurse (LPN)-A confirmed R30's wheelchair cushion was soiled with debris. LPN-A stated the cushion was cleaned once a month. LPN-A stated I wiped the cushion down yesterday with a Sani-wipe (sanitization wipe).

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 584 | Continued From page 20<br>R30 eats on the run (carrying food in wheelchair and eating) and messes things.<br><br>The Repairs/Replacements/Services (Maintenance and Housekeeping) policy revised 4/19/17, indicated Procedure: In order to facilitate expeditious repairs and/or replacement of certain fixtures, and for requesting other services provided in the plant operations and housekeeping departments, the following procedure should be followed: 1. A department supervisor should be made aware of the need or service required. 2. Associates will fill out the electronic requisition found in E-Source (computer system). 3. The request will be routed and assigned to appropriate persons in plant operations or housekeeping. | F 584 | | |
| F 638 SS=D | Qrtly Assessment at Least Every 3 Months<br>CFR(s): 483.20(c)<br><br>§483.20(c) Quarterly Review Assessment<br>A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to accurately correct the date of birth for 1 of 1 residents (R36) reviewed for Minimum Data Set (MDS) timeliness.<br><br>Findings include:<br><br>R36's face sheet printed on 7/26/18, indicated an admission date of 2/26/18, and a date of birth in 1933. The face sheet also indicated diagnoses that included unspecified dementia without | F 638 | Facility has systems in place to ensure accuracy of information utilized for quarterly review assessments.<br><br>Facility Eligibility Verification and Reviewing Admissions in Matrix procedures have been reviewed and found to be appropriate.<br><br>Re-education regarding above procedures and steps for following up on MDS alerts | 9/4/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 638 | Continued From page 21<br>behavioral disturbances.<br><br>R36's quarterly Minimum Data Set (MDS) dated 5/22/18, indicated R36 had severely impaired cognition. R36's MDS further indicated she had unclear speech (slurred or mumbled words) and sometimes understand others.<br><br>On 7/26/18, at 9:49 a.m., registered nurse (RN)-A indicated R36 was listed twice in their minimum data set (MDS) system. RN-A stated a previous employee had entered R36 with an incorrect date of birth (1932 instead of the correct 1933) and this error had not been fully corrected by the facility. This resulted in ongoing duplicate resident MDS entries and numbers for the resident (R36).<br><br>On 7/26/18, at 10:27 a.m., RN-A stated the previous employee had completed an entry and an admission MDS for R36. RN-A stated she had done R36's quarterly MDS. At the time of the quarterly MDS, 5/22/18 the Centers for Medicare and Medicaid Services (CMS) had sent a warning, and RN-A stated she corrected R36's date of birth going forward from that time, but did not merge or correct R36's entry and admission MDS. RN-A confirmed it had been past the 120 days for MDS submission for the original entry for R36, and stated she had not gone back to the original entry or admission MDS and corrected the birthdate. RN-A stated she should have corrected the birthday on the previous two MDS and stated she was not sure when it would have been fixed if not caught by the survey process.<br><br>The facility policy titled Comprehensive Assessments, dated 11/28/16, indicated the assessment must accurately reflect a resident's status, and each person who completes a portion | F 638 | will be provide for MDS and Business Office staff.<br><br>R36 date of birth has been corrected in system to prevent further occurrence.<br><br>Assistant Administrator or their designee is responsible for monitoring of this plan of correction. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 638 | Continued From page 22<br>of the assessment must sign and certify the accuracy of that portion of the assessment. The policy further indicated the NDS nurse and social services are responsible for completion of section A, identification information. | F 638 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide routine nail care for 1 of 4 residents (R22) reviewed for activities of daily living (ADLs), who was assessed to need staff assistance to meet ADLs.<br><br>Findings include:<br><br>R22's quarterly Minimum Data Set (MDS) an assessment, dated 5/1/18, identified R22 required extensive assist for personal hygiene.<br><br>R22's current care plan included Problem: Self-care deficit related to impaired ability to perform ADL's for oneself. Approaches included assist of one with grooming needs.<br><br>During observation on 7/24/18, at 9:00 a.m., R22's fingernails were observed to be long and had debris underneath the nail beds.<br><br>During observation on 7/25/18, at 10:22 a.m., R22's fingernails were observed to be uneven and had debris underneath the nail beds. | F 677 | Facility has systems in place to ensure residents unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene.<br><br>Activities of Daily Living / Hygiene policy was reviewed and found to be appropriate. R22 nail care was completed on 7/24/18 following surveyor observation.<br><br>R22 care plan and CNA care sheets reviewed and found to be appropriate.<br><br>Re-education will be provided for nursing staff regarding importance of routine nail care, need for additional cleaning / trimming as necessary between bath days and appropriate documentation of nail care completed.<br><br>Director of Nursing or their designee will conduct weekly audits to ensure compliance with routine nail care through | 9/4/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 677 | Continued From page 23<br><br>During interview on 7/26/18, at 10:03 a.m., nursing assistant (NA)-B stated resident fingernails were trimmed and cleaned on the resident bath day. NA-B stated R22's bath day was Tuesday p.m.<br><br>During interview and observation on 7/26/18, at 1:31 p.m., licensed practical nurse (LPN)-A stated the nursing assistants trimmed and cleaned nails on the resident bath day. LPN-A observed R22's fingernails and stated R22's right hand fingernails needed to be cleaned and trimmed and R22's left hand fingernails needed to be cleaned. LPN-A stated I will have NA-B trim R22's nails.<br><br>During interview on 7/26/18, at 1:50 p.m., the director of nursing (DON) stated she would expect fingernail care to be done weekly when the resident had a bath.<br><br>The Activities of Daily Living/Hygiene policy revised 7/1/13 indicated 7. Fingernail care: The optimal time to clean under nails, trim and shape them if necessary is after the weekly bath when the nails have been soaked in soapy water for a period of minutes. If the nails need cleaning in-between bath days, a bath basin suffices to soak the nail prior to care being provided. | F 677 | 10/31/18.<br><br>Director of Nursing or their designee are responsible for monitoring of this plan of correction. | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>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 | F 684 | | 9/4/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 684 | Continued From page 24<br>accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure upright wheelchair positioning for 1 of 1 resident (R30) reviewed for positioning.<br><br>Findings include:<br><br>R30's quarterly Minimum Data Set (MDS) assessment dated 5/15/18 indicated R30 required extensive assist with locomotion on unit. R30's resident Face Sheet dated 7/26/18, identified diagnoses of unspecified dementia with behavioral disturbance.<br><br>During an observation on 7/23/18, at 7:15 p.m., R30 was seated in her wheelchair and was leaning to the right. There was a cushion placed on the right side of R30's wheelchair that she was leaning up against.<br><br>During an observation on 7/24/18, at 9:45 a.m., R30 remained the same in her wheelchair leaning to the right.<br><br>R30's care plan, edited 7/23/18, included problem alteration in mobility related to osteoporosis. Chronic pain. Approaches included start date 7/23/18, has a padded armrest to provide comfort due to leaning to the right when in wheelchair.<br><br>R30's occupational therapy (OT) plan of care, identified start of care date 8/11/17, reason for referral to assess use of half lap tray in wheelchair and to provide proper wheelchair | F 684 | Facility has systems in place to ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the residents' choices.<br><br>Occupational Therapy (OT) referral made to reevaluate R30 wheelchair positioning.<br><br>R30 care plan and CNA care sheets will be reviewed and updated as necessary to address any new interventions / approaches as result of OT evaluation. Any applicable approaches will be included in<br>R30 treatment administration record (TAR)and monitored for effectiveness. R30 refusals of interventions / approaches will be documented.<br><br>Re-education will be provided for nursing staff regarding importance of ongoing monitoring and evaluation for resident wheelchair positioning needs.<br><br>Director of Nursing or their designee is responsible for monitoring of this plan of correction. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 684 | Continued From page 25 | F 684 | | |

positioning aid and modification recommendations to hold objects and liquids when propelling self in wheelchair on the unit floor. Patient currently seated in a 16 inch by 16 inch deep wheelchair with right arm lateral support/arm trough in place to assist in preventing right side leaning.

R30's OT discharge summary dated 9/7/17, indicated recommend continued use of padded right lateral support and arm trough to promote proper trunk positioning in wheelchair and to prevent risk of skin breakdown.

No further information was provided that addressed R30's position of leaning to the right in her wheelchair.

During an interview on 7/26/18, at 1:34 p.m., licensed practical nurse (LPN)-A confirmed R30 leaned to the right in her wheelchair. LPN-A stated (in regards to R30 leaning to the right onto the cushion placed on the right side of R30's wheelchair) she has always done that. R30 had an OT referral and they placed the cushion in her wheelchair she used now. LPN-A stated this was better than it was, as she used to hang over the armrest of the wheelchair completely. LPN-A reviewed R30's record and stated the last therapy order in R30's record was dated 8/11/17, which was an order to look at using a half tray, and stated unless therapy gave her the cushion instead of the half tray. LPN-A stated R30 was on hospice now and no one had recently addressed R30 leaning to the right in her wheelchair.

During interview on 7/26/18, at 1:55 p.m., the director of nursing (DON) stated R30 was always leaning in her wheelchair. We have had

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 684 | Continued From page 26<br>positioning pillows, an armrest extender and she takes it out. That is her go to position now.<br><br>The Position a Resident in Chair/Wheelchair policy dated 12/2002, indicated all nursing personnel are responsible to ensure all residents are properly positioned and in good body alignment while in a sitting position to prevent skin breakdown, relieve pressure and promote circulation. | F 684 | | |
| F 803 SS=D | Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)<br><br>§483.60(c) Menus and nutritional adequacy. Menus must-<br><br>§483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;<br><br>§483.60(c)(2) Be prepared in advance;<br><br>§483.60(c)(3) Be followed;<br><br>§483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;<br><br>§483.60(c)(5) Be updated periodically;<br><br>§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and<br><br>§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make | F 803 | | 9/4/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 803 | Continued From page 27<br>personal dietary choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure preference of food choices were offered for 1 of 3 residents (R65) reviewed for food.<br><br>Findings include:<br><br>R65 had been interviewed on 7/23/18, at 4:04 p.m., R65 stated I eat in my room and they are supposed to come every week and ask me what I want to eat. So far, this week they have not come to ask me and they have not come to ask me my preference for my meal tonight. The nursing assistants tell me if I do not like what I get; they will get something different for me. R65 stated I would like to have a time set up where they would come on Saturday, Sunday or even Friday afternoon, so 1 would have my menu choices put in for the following week.<br><br>During an interview on 7/25/18, at 10:10 a.m., R65 stated (in regards to menu choices) I asked a nursing assistant to help me with that on Tuesday. Usually someone from dietary will come up, but not always. No one came so I had a nursing assistant help me.<br><br>R65's welcome visit note, dated 6/5/18, indicated resident able to make food choices. Culinary will provide meal trays three times a day, offer snacks twice daily and select menu to unit.<br><br>R65's Admission Nutrition Assessment dated 6/7/18 indicated R65 ate meals independently on unit. | F 803 | Facility supports resident right to make personal dietary choices.<br><br>Facility has reviewed Select Menu process and will develop policy to reflect this.<br><br>R65 name has been added to facility Select Menu list. Director of Culinary Services met with R65 on 8/9/18 to review process and clarify resident preferences. R65 has requested weekly assistance with completion of Select Menu to be provided by culinary staff. R65 care plan will be updated to reflect this.<br><br>Education will be provided for A3 Culinary Aides and managers related to the Select Menu process.<br><br>Director of Culinary Services or their designee are responsible for monitoring of this plan of correction. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 803 | Continued From page 28<br>The facility resident menus (a list of residents to provide a menu to), dated 7/23/18, identified R65 was not listed as a resident to receive a menu.<br><br>On 7/25/18, at 10:56 a.m., culinary service director (CSD)-F stated when a resident was admitted to the facility and the resident chooses to eat in their room the resident was given a select menu. We put out the menu each week and the resident chooses on Mondays what they wish to have to eat. I ask them on admission where they want to eat when I do the welcome visit and the registered dietician asks them again when she completes the assessment. CSD-F reviewed R65's welcome visit note, dated 6/5/18 and Admission Nutrition Assessment, dated 6/7/18, and stated R65 was receiving meals in her room and was to be offered the select menu. CSD-F reviewed the facility list of resident's that eat in their room dated 7/23/18. CSD-F stated R65 was not on the list and R65 should be on the list and be provided a menu. CSD-F stated that was my oversight, I will follow up with R65 right away.<br><br>The Alternative Menu policy revised 3/6/17 indicated Procedure: 1. At the time of admission each resident/family is asked if they desire a select menu or if they wish to eat meals in the main dining room, where table service is the process. 2. Weekly menus are posted on each unit as well as distributed to all residents that want a select menu that will be filled out weekly. If a resident needs help completing their menu, a culinary team member or family member will assist them. | F 803 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f) | F 880 | | 9/4/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 880 | Continued From page 29<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to: | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 880 | Continued From page 30<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure professional standards of practice for glove use and handwashing was followed by housekeeping between cleaning resident bathrooms for 5 of 5 rooms (415, 414, 416, 502 and 503).<br><br>Findings include:<br><br>During an observation on 7/23/18, at 4:31 p.m., housekeeper (H)-A was observed to place one | F 880 | Facility maintains infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent development and transmission of communicable disease and infection.<br><br>Hand Hygiene and Standard Precautions policies were reviewed and found to be appropriate. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 880 | Continued From page 31<br>glove on right hand. H-A had no glove on left hand. H-A carried toilet brush and cleaner in room 415 and cleaned the toilet. H-A walked out into the hallway, carried a spray bottle and a rag back into the bathroom in room 415, and cleaned other surfaces in the bathroom. H-A walked out of room 415, removed glove, applied new glove on right hand and the left hand remained gloveless. H-A walked into room 414 with toilet brush, cleaner and a spray bottle. H-A cleaned room 414's bathroom, walked back out into hallway and removed glove. H-A then applied glove on right hand and walked into room 416 to clean the bathroom. H-A did not wear a glove on the left hand when cleaning bathrooms and did not wash hands between cleaning rooms.<br><br>During an interview on 7/23/18, at 5:43 p.m., H-A stated I did not wash hands between cleaning rooms today. H-A confirmed he wore only one glove on his right hand when cleaning in the resident bathrooms.<br><br>During an observation on 7/24/18, at 9:50 a.m., housekeeper (H)-B was in room 502 cleaning the bathroom and had gloves on both hands. H-B walked out of room 502, removed gloves and went back into room 502 to sweep the floor. H-B applied gloves, walked into room 503 and cleaned the bathroom. H-B walked out of room 503, removed gloves and went back into room 503 to sweep the floor. H-B walked out of room 503 and washed hands. H-B lacked to wash hands between cleaning rooms. H-B stated if my hands feel gross, dirty I wash them. I use hand sanitizer. I wear gloves. H-B confirmed had not washed hands between cleaning the rooms.<br><br>During an interview on 7/26/18, at 12:58 p.m., | F 880 | Infection control program education provided at Housekeeping team meeting on 7/23/18. Re-education provided regarding hand washing, use of hand sanitizer and personal protective equipment (PPE) provided at All Staff meetings held on 8/7/18 and 8/8/18. Additional training will be provided for housekeeping staff at department meeting scheduled for 8/31/18. Training will include a return demonstration of hand hygiene competency.<br><br>Infection Preventionist / QMC or their designee will conduct weekly audits of Housekeeping staff to ensure compliance with proper hand hygiene approaches through 10/31/18.<br><br>Director of Nursing or their designee is responsible for monitoring of this plan of correction. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 880 | Continued From page 32<br>housekeeping manager (HM)-B stated I would expect gloves to be worn on both hands and hands to be washed after leaving a room.<br><br>During an interview on 7/26/18, at 2:53 p.m., quality management coordinator (QMC)-C stated she would expect housekeeping to wash hands anytime gloves are changed.<br><br>The facility policy Hand Hygiene, dated 6/17, indicated infection prevention begins with the basic hand hygiene. By following proper hand hygiene practices, associates will reduce the spread of potentially deadly germs, as well as reduce the risk of healthcare provider colonization caused by germs acquired from the residents. Times to perform hand hygiene are, but not limited to: after removing gloves or aprons. | F 880 | | |
| F 919 SS=D | Resident Call System<br>CFR(s): 483.90(g)(2)<br><br>§483.90(g) Resident Call System<br>The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area.<br><br>§483.90(g)(2) Toilet and bathing facilities.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to ensure a bathroom call light was functioning for 1 of 16 residents (R36) reviewed for functioning call lights on the fifth floor.<br><br>Findings include: | F 919 | Facility is equipped with a system which allows residents to call for staff assistance through a communication system which relays the call directly to a staff member or centralized work area.<br><br>Advanced Wireless Call System policy | 9/4/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 919 | Continued From page 33<br><br>R36's face sheet printed on 7/26/18, indicated diagnoses that included repeated falls, unspecified dementia without behavioral disturbances, difficulty in walking, constipation, and muscle weakness. The face sheet also indicated R36 was currently in room 525, bed A.<br><br>R36's quarterly Minimum Data Set (MDS) dated 5/22/18 indicated R36 had severely impaired cognition, was frequently incontinent of bowel and bladder, and needed limited assistance to walk in her room and in the corridor.<br><br>On 7/24/18, at 9:19 a.m., the call light in room 525's bathroom was found to not be functioning. Maintenance (M)-A stated he could tell the pull cord was broken just by looking at it and confirmed it did not work.<br><br>On 7/26/18, at 7:24 a.m., M-A stated again that the call light in room 525 was broken and the maintenance department had not been notified of the fact that it was broken prior to surveyor notification. M-A stated he fixed the call light immediately on 7/24/18. M-A stated the maintenance department often gets eSource notifications from other staff when repairs need to be complete, but they had not been notified that the call light in room 525 needed repair. M-A also stated they do not do routine checks, or physical inspections on call light function.<br><br>On 7/26/18, at 8:56 a.m., the environmental services director (ESD) stated the facility used an "I- Cloud" reports on the computer to tell if a call light was functioning. The ESD stated he did not know if they did any physical walk around inspections to check call light function, but didn't | F 919 | has been reviewed and will be updated to reflect current approaches.<br><br>Re-education provided for all staff at meetings held 8/7/18 and 8/8/18 regarding importance of identifying and reporting maintenance concerns. Example used in training included a maintenance call light concern.<br><br>Director of Environmental Services, Director of Nursing and Assistant Administrator held call with Advanced Wireless on 8/15/18 to review call light reporting tools available. Procedure for possible malfunctions through use of online reporting is being developed.<br><br>Director of Environmental Services developing procedure for regular monitoring of call lights to identify concerns that may not be reflected in the Advanced Wireless reports (i.e. call light cord condition). This will include a schedule for physical inspection of call lights.<br><br>Director of Environmental Services or their designee is responsible for monitoring of this plan of correction. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING _____ B. WING _____ | 07/26/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SAINT ANNE EXTENDED HEALTHCARE | 1347 WEST BROADWAY 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 |
|---|---|---|---|---|
| F 919 | Continued From page 34<br>know if it was necessary, as the I-Cloud system was "pretty thorough".<br><br>Review of the facility's Location Summary Report for 7/10/18 to 7/26/18, indicated the call light in bathroom 525 was not on the list for "check in failure" or low battery; therefore it was deemed to be working. The Location Summary Report does not indicate if the pull cord was functioning or broken.<br><br>The Repairs/Replacement/Services (Maintenance and Housekeeping) policy, revised 3/4/8, indicated a department supervisor would fill out the electronic requisition found in E-Source and the request would be routed to the appropriate persons in Plant Operations or housekeeping. | F 919 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **07/26/2018** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SAINT ANNE EXTENDED HEALTHCARE** | **1347 WEST BROADWAY**<br>**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 |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS | K 000 | | |

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 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (St. Anne Extended Healthcare) 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES
( K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St Paul, MN 55101-5145, or

By email to:
Marian.Whitney@state.mn.us and

EPOC

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 08/23/2018 |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **07/26/2018** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SAINT ANNE EXTENDED HEALTHCARE** | **1347 WEST BROADWAY**<br>**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 |
|---|---|---|---|---|
| K 000 | Continued From page 1<br>Angela.Kappenman@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br><br>The Facility is a 6 story building with a partial basement. The facility was constructed in 1962 and was determined to be of Type II(222) construction.<br><br>The building is protected by a full fire sprinkler system. 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.<br><br>The facility has a capacity of 109 beds and had a census of 100 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 311 SS=E | Vertical Openings - Enclosure<br>CFR(s): NFPA 101<br><br>Vertical Openings - Enclosure<br>2012 EXISTING<br>Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings | K 311 | | 9/4/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **07/26/2018** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SAINT ANNE EXTENDED HEALTHCARE** | **1347 WEST BROADWAY**<br>**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 |
|---|---|---|---|---|
| K 311 | Continued From page 2<br>between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6<br>If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box.<br>This REQUIREMENT is not met as evidenced by:<br>The facility failed to comply with Life Safety Code ( 8.6., 19.3.1.1 through 19.3.1.6 )<br><br>This deficient practice could affect the safety of all ( 100 ) the residents, staff and visitors within the smoke compartment/ Facility.<br>Findings Include:<br><br>On facility tour between 09:00 AM and 03:00 PM on 07/26/2018, observations and staff interview revealed the following:<br><br>During walk-through of the facility - vertical penetrations: ( 1 ) 5th FL - missing ceiling tile in the oxygen storage room - adjacent to RM 512; ( 2 ) 5th FL missing ceiling tile RM 508; ( 3 ) 1st FL missing ceiling tile in RM 141; ( 4 ) 1st FL missing ceiling time RM 107<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 311 | Facility has systems in place to ensure stairways, elevator shafts, light and ventilation shafts, chutes and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. On 7/27/18, ceiling tiles were replaced to address vertical penetrations (1)5th Floor missing ceiling tile in oxygen room (2)5th FL missing ceiling tile RM508 (3) 1st FL missing ceiling tile in RM141 and (4) 1st FL missing ceiling tile RM107.<br>Maintenance Safety Checklist has been developed to monitor for and address possible issues with ceiling tiles, electrical panel security, extension cords / power strip use and oxygen tank storage.<br>Re-education provided for all staff at meetings held 8/7/18 and 8/8/18 regarding importance of identifying and reporting maintenance related concerns.<br>Education will be provided for maintenance technicians related to expectation around Safety Checklist.<br>Director of Environmental Services is responsible for monitoring of ths plan of correction. | |
| K 353 | Sprinkler System - Maintenance and Testing | K 353 | | 9/4/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **07/26/2018** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SAINT ANNE EXTENDED HEALTHCARE** | **1347 WEST BROADWAY**<br>**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 |
|---|---|---|---|---|
| K 353 SS=F | Continued From page 3<br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing<br>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.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This REQUIREMENT is not met as evidenced by:<br>The facility failed to comply with Life Safety Code ( 9.7.5, 9.7.7, 9.7.8, and NFPA 25 )<br><br>This deficient practice could affect the safety of all ( 100 ) the residents, staff and visitors within the smoke compartment/ Facility.<br>Findings Include:<br><br>On facility tour between 09:00 AM and 03:00 PM on 07/26/2018, observations, staff interview, and documentation reviewed revealed the following:<br><br>Documentation review as-well-as visual inspection of sprinkler gauges ( marked 2012 ) - indicates 5yr sprinkler system maintenance has not be completed | K 353 | Facility has systems in place to ensure sprinkler system maintenance and testing are completed in accordance with NFPA 25. Required sprinkler gauge inspection was completed on 8/20/18 and 8/21/18. Director of Environmental Services will review inspection report when it is made available and follow through with any recommended action. Evidence of inspection and follow up action will be filed in facility Life Safety Code binder. Education will be provided for Director of Environmental Services related to required sprinkler system inspections. Director of Environmental Services or their designee is responsible for | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **07/26/2018** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SAINT ANNE EXTENDED HEALTHCARE** | **1347 WEST BROADWAY**<br>**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 |
|---|---|---|---|---|
| K 353 | Continued From page 4<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 353 | monitoring of this plan of correction. | |
| K 511 SS=E | Utilities - Gas and Electric<br>CFR(s): NFPA 101<br><br>Utilities - Gas and Electric<br>Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life.<br>18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility failed to comply with Life Safety Code ( 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 )<br><br>This deficient practice could affect the safety of all ( 20 ) the residents, staff and visitors within the smoke compartment/ Facility.<br>Findings Include:<br><br>On facility tour between 09:00 AM and 03:00 PM on 07/26/2018, observations and staff interview revealed the following:<br><br>During walk-through of the facility - unsecured electrical panel in resident corridor - 5th FL close to RM 536<br><br>This deficient practice was confirmed by the | K 511 | Facility has systems in place to ensure electrical wiring and equipment provide no hazard to life. On 7/27/18, Maintenance staff conducted walk through of facility to ensure all electrical and data panels were secure. Maintenance Safety Checklist has been developed to monitor for and address possible issues with ceiling tiles, electrical panel security, extension cords / power strip use and oxygen tank storage. Re-education provided for all staff at meetings held 8/7/18 and 8/8/18 regarding importance of identifying and reporting maintenance related concerns. Education will be provided for maintenance technicians related to expectation around use of Safety | 9/4/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **07/26/2018** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SAINT ANNE EXTENDED HEALTHCARE** | **1347 WEST BROADWAY**<br>**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 |
|---|---|---|---|---|
| K 511 | Continued From page 5<br>Facility Maintenance Director at the time of discovery. | K 511 | Checklist and keeping electrical and data panels secured. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction. | |
| K 712 SS=E | Fire Drills<br>CFR(s): **NFPA 101**<br><br>Fire Drills<br>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.<br>19.7.1.4 through 19.7.1.7<br>This **REQUIREMENT** is not met as evidenced by:<br>The facility failed to comply with Life Safety Code ( 19.7.1.4 through 19.7.1.7 )<br><br>This deficient practice could affect the safety of all ( 100 ) the residents, staff and visitors within the smoke compartment/ Facility.<br>Findings Include:<br><br>On facility tour between 09:00 AM and 03:00 PM on 07/26/2018, observation and documentation reviewed revealed the following:<br><br>Documentation review indicated that the Facility is not consistent in following guidelines for time-frame separation when conducting fire drills. Documentation was not available for the 3rd | K 712 | 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.<br>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.<br>Director of Environmental Services will review each fire drill report to ensure they are filled out completely and reflect all required documentation. Director of | 9/4/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **07/26/2018** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SAINT ANNE EXTENDED HEALTHCARE** | **1347 WEST BROADWAY**<br>**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 |
|---|---|---|---|---|
| K 712 | Continued From page 6<br>quarter of the year for 3rd shift.<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 712 | Environmental Services will forward a copy of next 6 fire drill reports to Assistant Administrator for additional review. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction. | |
| K 920 SS=E | Electrical Equipment - Power Cords and Extens<br>CFR(s): NFPA 101<br><br>Electrical Equipment - Power Cords and Extension Cords<br>Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles 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 purpose for which it was installed and meets the conditions of 10.2.4.<br>10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5<br>This REQUIREMENT is not met as evidenced by:<br>The facility failed to comply with Life Safety Code ( 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 ) | K 920 | Facility has systems in place to ensure power strips and extension cords are not used as a substitute for permanent wiring. | 9/4/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **07/26/2018** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SAINT ANNE EXTENDED HEALTHCARE** | **1347 WEST BROADWAY**<br>**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 |
|---|---|---|---|---|
| K 920 | Continued From page 7<br><br>This deficient practice could affect the safety of all ( 100 ) the residents, staff and visitors within the smoke compartment/ Facility.<br>Findings Include:<br><br>On facility tour between 09:00 AM and 03:00 PM on 07/26/2018, observations and staff interview revealed the following:<br><br>During walk-through of the facility - observed the following: ( 1 ) 1st FL - extension cord being used as permanent wiring from the dry goods storage room to open area of kitchen area to power large pedestal fan; ( 2 ) 5th FL - appliance connected to power-strip - Refrigerator<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 920 | (1) 1st FL extension cord being used as permanent wiring to power a large pedestal fan was removed. A new outlet was installed for use with fan. (2) Power strip being used to power 5th FL appliance was removed. Also removed appliances that were no longer being used to eliminate need for any additional power source. Maintenance Safety Checklist has been developed to monitor for and address possible issues with ceiling tiles, electrical panel security, extension cords / power strip use and oxygen tank storage. Re-education provided for all staff at meetings held 8/7/18 and 8/8/18 regarding importance of identifying and reporting maintenance related concerns. Education will be provided for maintenance technicians related to expectation around use of Safety Checklist and need to identify / address situations in which power and extension cords are being inappropriately. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction. | |
| K 923 SS=E | Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101<br><br>Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.<br>>300 but <3,000 cubic feet<br>Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or | K 923 | | 9/4/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **07/26/2018** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SAINT ANNE EXTENDED HEALTHCARE** | **1347 WEST BROADWAY**<br>**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 |
|---|---|---|---|---|
| K 923 | Continued From page 8<br>gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.<br>Less than or equal to 300 cubic feet<br>In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.<br>A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."<br>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.<br>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>The facility failed to comply with Life Safety Code ( 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) )<br><br>This deficient practice could affect the safety of all ( 25 ) the residents, staff and visitors within the smoke compartment/ Facility.<br>Findings Include:<br><br>On facility tour between 09:00 AM and 03:00 PM on 07/26/2018, observations and staff interview | K 923 | Facility has systems in place to ensure appropriate storage of gas cylinders and containers. On 7/26/18, oxygen containers were moved to appropriate side of storage closet on 4th FL to ensure defined separation. Director of Environmental Services and Director of Nursing have developed a plan to clearly mark where empty and full oxygen containers should be stored within storage | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **07/26/2018** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **SAINT ANNE EXTENDED HEALTHCARE** | **1347 WEST BROADWAY**<br>**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 |
|---|---|---|---|---|
| K 923 | Continued From page 9<br>revealed the following:<br><br>During walk-through of the facility - 4th FL oxygen room - cylinders were mixed together ( empty / full ) - no defined separation<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 923 | rooms on each unit. Each unit storage room will be set up to include a physical vertical barrier between empty and full containers. Approach will include signage to clearly indicate where empty and full containers should be stored.<br>Re-education will be provided for nursing staff related to appropriate storage of oxygen containers. Maintenance Safety Checklist has been developed to monitor for and address possible issues with ceiling tiles, electrical panel security, extension cords / power strip use and oxygen tank storage. Education will be provided for maintenance technicians related to expectation around use of Safety Checklist. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction. | |