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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Y89B

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 **07/10/2014** (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:
X 1. Acceptable POC

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 07/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/22/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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
Posted 09/15/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/16/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN-24-5233

On 07/10/14, a Post Certification Revisit (PCR) was completed by the Department of Health and on 07/01/14, the Minnesota Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility had achieved substantial compliance pursuant to the 05/09/2014 standard survey, effective 6/30/2014 Refer to the CMS 2567b for both health and life safety code. Effective 06/30/2014, the facility is certified for 109 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245233

July 16, 2014

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

Dear Ms. Barton:

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 June 30, 2014 the above facility is certified for or recommended 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, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 16, 2014

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

RE: Project Number S5233024

Dear Ms. Barton:

On May 20, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 9, 2014 that included an investigation of complaint number . This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On July 10, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on July 1, 2014 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 May 9, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 30, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 9, 2014, effective June 30, 2014 and therefore remedies outlined in our letter to you dated May 20, 2014, 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, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245233	01 - MAIN BUILDING 01	7/1/2014

Name of Facility	Street Address, City, State, Zip Code
SAINT ANNE EXTENDED HEALTHCARE	1347 WEST BROADWAY WINONA, MN 55987

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0020	06/30/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/KFD	07/16/2014	31221	07/01/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
5/7/2014	

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245233	A. Building B. Wing **01 - MAIN BUILDING 01**	7/1/2014

Name of Facility	Street Address, City, State, Zip Code
SAINT ANNE EXTENDED HEALTHCARE	1347 WEST BROADWAY WINONA, MN 55987

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0020	06/30/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/kfd	07/16/2014	25822	07/01/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?
5/7/2014	YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Y89B

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 **05/09/2014** (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:
X 1. Acceptable POC

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Danette Bakken, HFE II 05/30/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/12/2014 (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
Posted 06/16/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN-24-5233

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in the facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 20, 2014

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

RE: Project Number S5233024 & H5233015

Dear Ms. Barton:

On May 9, 2014, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the May 9, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5233015 that was found to be unsubstantiated.

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 a "F" tag), i.e., the plan of correction should be directed to:

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904

Telephone: (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 June 18, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 August 9, 2014 (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 November 9, 2014 (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
Division of Compliance Monitoring
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 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

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 _____	05/09/2014

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 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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. An investigation of H5233015 was completed. The complaint was not substantiated.	F 000		
F 160 SS=D	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to convey resident funds deposited into a trust account within 30 days of death for 1 of 3 residents (R107) who had expired. Findings include: R107's face sheet indicated that R107 expired on 02/14/14. The facility's trust fund statement for R107 was reviewed and indicated that R107's	F 160	F160 SS = D Facility has system to ensure upon death of a resident with a personal fund deposited with the facility, the facility will convey within 30 days the funds and a final accounting of the funds, to the individual or probate jurisdiction administering the resident□s estate.	6/18/14

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

Electronically Signed | 05/30/2014

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 _____	05/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE EXTENDED HEALTHCARE	1347 WEST BROADWAY WINONA, MN 55987

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F 160	Continued From page 1 remaining trust fund balance of $20.00 and had not been conveyed to the family until 5/05/14 (three months from date of death). On 5/9/14 at 9:00 a.m. during an interview with the business services coordinator (BSC), BSC confirmed that R107's remaining balance of her trust fund was not conveyed until 5/05/14. BSC confirmed that it was sent out, but not within 30 days of R107's death. The facility's policy titled Resident Trust Account dated January 2010 identified when a resident is discharged due to death, that within 3 weeks the Resident Trust Designee audits the trust to verify all deposits and withdrawals have been posted. A check request is submitted to have a check processed to close the account.	F 160	Facility policy of Resident Trust Accounts was reviewed and found to be appropriate. Facility staff will review the policy and will add to the End of the Month SNF Task List. Assistant Administrator or their designee are responsible for monitoring of this plan of correction. Completion Date: 6/18/14	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care	F 164		6/18/14

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F 164	Continued From page 2 institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure confidentiality of medical interventions for 1 of 23 residents (R10) was kept from other residents, staff and visitors view. Findings include: R10 was observed to have a paper sign with R10's name on the bathroom mirror that directed colostomy care and shaving on 5/6/14 at 2:30 p.m. The sign read in large typed letters R10's first and last name and "DO NOT REMOVE COLOSTOMY BAG YOURSELF PLEASE ASK FOR STAFF ASSISTANCE." Also read, " Please Shave!! Or you ' ll be very hairy." R10's bathroom door was wide open and the sign was visible to any person in R10's room. R10 was admitted to the facility on 4/25/01, with diagnosis that included brain injury and hemiplegia, according to the facility resident admission record. The facility identified R10 on the quarterly Minimum Data Set (MDS); an assessment dated 2/27/14, to have moderate cognitive impairment,	F 164	F164 SS = D Facility has systems in place to ensure the residents have the right to personal privacy and confidentiality of his or her personal and clinical record. Facility policy of Privacy and Dignity of Residents was reviewed and found to be appropriate. Facility nursing staff will review the policy and the expectation to follow the policy. The sign in R10 room was removed on 5/6/14. Care plan was reviewed and found to be accurate. Director of Nursing or their designee are responsible for monitoring of this plan of correction. Completion Date: 6/18/14	

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F 164	Continued From page 3	F 164		

required extensive assist of two staff for activities of daily living, and required extensive assist of one staff for personal hygiene which included shaving.

Document review of R10 ' s care plan dated 7/10/02; revealed staff directed R10 had potential for breach of privacy and dignity related to communal living in extended care facility. Goal included resident/visitors would express satisfaction with provision of privacy and dignity. Approach included staff were to follow privacy/dignity policy, R10 refused to wear name band, wear medical alert bracelet when resident chooses.

Document review of R10 ' s care plan dated 5/1/01, revealed staff directed R10 had self-care deficit related to closed head injury and weakness. Goal included will dress upper body with minimal assistance. Approach included help complete shaving to ensure dignity, occasionally will request not to be shaved, as he likes having facial hair.

On 5/7/14, at 12:30 p.m., R10 was observed in his room with a full beard and mustache. During interview at that time, R10 stated he went to facility beauty shop for beard and mustache trims.

During interview on 5/8/14, at 8:15 a.m., registered nurse (RN)-A stated R10 went to the facility beauty shop weekly for a beard and mustache trim. RN-A stated the bathroom door was always open to allow R10 to enter by self with wheelchair.

During interview on 5/8/14, at 11:30 a.m., nursing assistant (NA)-A stated was aware of the sign on

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F 164	Continued From page 4 mirror and stated it had been there a " long time. " Document review of facility Dignity and Respect of Each Resident policy dated 5/17/06, revealed to treat a resident's room and all personal belongings in a careful, respectful and private manner.	F 164		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225		6/18/14

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F 225	Continued From page 5 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to report allegations of abuse/neglect immediately to the administrator and to the state agency for 1 of 3 residents (R110) reviewed for allegations of abuse and neglect. Findings include: R110 was observed and interview on 5/06/14 at 11:39 a.m. R110 indicated that she felt that she had been abused during an incident with a nursing assistant. R110 stated that she had been sitting on the toilet and the nursing assistant lunged at her and then tore off her brief that she had on. R110 stated she doesn't remember what she said to the nursing assistant that prompted this. R110 could not remember when the incident took place. R110 stated that she had been afraid of the nursing assistant and that this nursing assistant maybe would not help her if she needed help. R110 stated that she did report this incident to the staff. According to the signed physician orders dated 4/8/14, R110 was admitted to the facility on 4/19/13 with diagnoses including: dependent	F 225	F225 SS = D Facility has system to ensure policies and procedures prohibiting mistreatment, neglect, abuse of residents and misappropriation of resident property are in place. Facility policy regarding Abuse Prevention Plan was reviewed and found to be appropriate. Facility staff will review the policy and expectation to investigate and report any applicable concerns to the Administrator and state agency within required timeframes. Administrator or their designee are responsible for monitoring of this plan of correction. Completion Date: 6/18/14	

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F 225	Continued From page 6 personality disorder, depressive disorder. According to the care area assessment (CAA) for cognitive loss/dementia dated 4/8/14, indicated that R110 was cognitively intact but chose not to participate in the brief interview for mental status (BIMS). The activities for daily living (ADL) CAA dated 4/8/14 indicated that R110 had an electric scooter for locomotion on and off unit. R110 required extensive assist with bed mobility, transfer, dressing, toileting, hygiene and total assist with bathing; required staff assists to stabilize during transition and few steps of ambulation; was morbidly obese. The facility concern form indicated R110 told the staff about the incident with the staff person being aggressive dated 11/27/13 at 1:47 a.m. Included on the concern form R110 indicated that the nursing assistant assisted her with cares in the bathroom, and did not apply a paper towel to her abdominal fold correctly, and when R110 asked the nursing assistant to do it better, that the nursing assistant just stood there. R110 then asked the nursing assistant was she going to help her or get someone else. R110 indicated that the nursing assistant grabbed it and ripped it out of the fold. R110 was told by the nursing assistant that the nurse was on break and there was no one else on that floor. R110 then called another floor and talked to another nurse. The nurse from the other floor arrived and talked to R110 and told her that she was safe and that the nursing assistant would not hit her. The concern form indicated that R110 indicated to the nurse from another floor that " For a minute there I thought she was going to hit me." The concern was assigned to the social worker on 12/3/13 at 4:00 p.m. to investigate (this was 6 days after the	F 225		

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F 225	Continued From page 7	F 225		

resident informed the staff of the alleged abuse.)

During an interview with the Administrator and the Director of Nursing (DON) on 5/7/14 at 4:50 p.m. the Administrator indicated that she did remember the concern and that they did follow up on it. The DON stated that R110 did not feel afraid of the nursing assistant.

The DON during an interview on 5/9/14 at 10:24 a.m., when questioned about the process if there was an allegation of abuse, indicated that if a resident issues a concern that it would be reported to the charge nurse and that the charge nurse would start an investigation immediately. The Administrator would be notified immediately and that the staff usually notified the DON. If it needed to be reported they would immediately report it to the state and fax it to the county. The social worker or the DON would continue with the investigation. It would be submitted within the 5 days. The DON confirmed that this incident was not reported as a vulnerable adult report to the state agency. The DON indicated that R110 was not afraid of the nursing assistant and did not feel it was an incident needing to be reported.

The policy titled Abuse Prevention Plan revised 3/1/13 indicated that all accidents and incidents as well as allegations of abuse, neglect and/or financial exploitation will be investigated by Social Services, Director of Nursing or their appropriate designees. Measures would be taken to identify the source of the alleged abuse and prevent future incidents. Any employee must report suspected maltreatment if: he/she has knowledge of maltreatment or a vulnerable adult or has reasonable cause to believe that a vulnerable adult has been maltreated. The staff

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F 225	Continued From page 8 was directed, after safeguarding the resident, to report the information to their supervisor. The supervisor in turn must immediately report all suspected maltreatment to the Minnesota Department of Health (MDH). The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriate of resident property are reported immediately to the Administrator. If the Administrator is not available, then his designee should be notified immediately. It will be documented that the Administrator or designee was informed of the report.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement their Abuse Prevention plan which indicated all allegations of abuse were to be immediately reported to the administrator and immediately reported to the state agency for 1 of 3 residents (R110) who had reported an allegation of abuse. Findings include: Document review of the facility Abuse Prevention Plan revised 3/1/13 indicated that all accidents	F 226	F226 SS = D Facility has system to ensure policies and procedures prohibiting mistreatment, neglect, abuse of residents and misappropriation of resident property are in place. Facility policy regarding Abuse Prevention Plan was reviewed and found to be appropriate. Facility staff will review the policy and expectation to investigate and report any applicable concerns to the	6/18/14

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F 226	Continued From page 9 and incidents as well as allegations of abuse, neglect and/or financial exploitation will be investigated by Social Services, Director of Nursing or their appropriate designees. Measures would be taken to identify the source of the alleged abuse and prevent future incidents. Any employee must report suspected maltreatment if: he/she has knowledge of maltreatment or a vulnerable adult or has reasonable cause to believe that a vulnerable adult has been maltreated. The staff was directed, after safeguarding the resident, to report the information to their supervisor. The supervisor in turn must immediately report all suspected maltreatment to both the Minnesota Department of Health (MDH). The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriate of resident property are reported immediately to the Administrator. If the Administrator is not available, then his designee should be notified immediately. It will be documented that the Administrator or designee was informed of the report. During observation and interview with R110 on 5/06/14 at 11:39 a.m. R110 indicated that she felt that she had been abused during an incident with a nursing assistant. R110 stated that she had been sitting on the toilet and the nursing assistant lunged at her and tore off her brief that she had on. R110 stated she doesn't remember what she said to the nursing assistant that prompted this. R110 could not remember when the incident took place. R110 stated that she had been afraid of the nursing assistant and that this nursing assistant maybe would not help her if she needed help. R110 stated that she did report this	F 226	Administrator and state agency within required timeframes. Administrator or their designee are responsible for monitoring of this plan of correction. Completion Date: 6/18/14	

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F 226	Continued From page 10	F 226		

incident to the nurse.

The facility concern form indicated that the date of the alleged allegation made by R110 was dated 11/27/14 at 1:47 a.m. that concerned a complaint with a staff. R110 indicated that the nursing assistant assisted her with cares in the bathroom, and did not apply a paper towel to her abdominal fold correctly, and when R110 asked the nursing assistant to do it better, that the nursing assistant just stood there. R110 then asked the nursing assistant she was going to help her or get someone else. R110 indicated that the nursing assistant grabbed it and ripped it out of the fold. R110 was told by the nursing assistant that the nurse was on break and there was no one else on that floor. R110 then called another floor and talked to another nurse. The nurse from the other floor arrived and talked to R110 and told her that she was safe and that the nursing assistant would not hit her. The concern form indicated that R110 indicated to the nurse from another floor that "For a minute there I thought she was going to hit me." The concern was assigned to the social worker on 12/3/14 at 4:00 p.m. to investigate.

During an interview with the Administrator and the Director of Nursing (DON) on 5/7/14 at 4:50 p.m. the Administrator indicated that she did remember the concern and that they did follow up on it. The DON stated that R110 did not feel afraid of the nursing assistant.

The DON during an interview on 5/9/14 at 10:24 a.m., when questioned about the process if there was an allegation of abuse, indicated that if a resident issues a concern that it would be reported to the charge nurse and that the charge

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F 226	Continued From page 11 nurse would start an investigation immediately. The Administrator would be notified immediately and that the staff usually notified the DON. If it needed to be reported they would immediately report it to the state and fax it to the county. The social worker or the DON would continue with the investigation. It would be submitted within the 5 days. The DON confirmed that this incident was not reported as a vulnerable adult report to the state agency. The DON indicated that R110 was not afraid of the nursing assistant and did not feel it was an incident needing to be reported.	F 226		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the residents' environment was free of foul odors for 1 of 1 resident (R129) who resided in room 313. Findings include: On 5/6/14, at 2:50 p.m. during an interview and observation of R129 in his room there was a strong urine odor present. On 5/7/14 at 7:45 p.m., there was a strong urine odor in R129 ' s room. During an interview on 5/7/14 at 7:46 p.m., nursing assistant (NR)-B stated R129 just received a new floor in his room a couple months	F 253	F253 SS = D Facility has systems in place to ensure the residents have the right to housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. Facility policy of Odor Control was written. Facility nursing and housekeeping staff will review the policy and the expectation to follow it. Room, bathroom and clothing hamper for R 129 is being checked on a routine basis by nursing staff and housekeeping staff. Appropriate cleaning items are being used	6/18/14

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SAINT ANNE EXTENDED HEALTHCARE	1347 WEST BROADWAY WINONA, MN 55987

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F 253	Continued From page 12 ago. NR-B stated R129 was independent with toileting and will urinate all over the floor in the bathroom missing the toilet and will pee in the sink. NR-B stated R129 ' s room smelled like urine. NA-B stated housekeeping staff cleaned the whole floor in his room and bathroom twice a day but this did not help with the urine smell. NA-B stated the urine smell in Room 313 was an ongoing, terrible issue. During an interview on 5/8/14 at 10:32 a.m., nursing assistant (NR)-C stated the odor in room 313 was urine. NR-C stated R129 liked to stand up to urinate and would miss the toilet. NR-C stated R129 was not incontinent of urine when in bed and stated if he were to have an accident would call for assistance. NR-C stated he felt the urine was primarily on the floor and had never noticed R129 ' s clothes being wet. During an interview on 5/8/14 at 10:11 a.m., housekeeper (H)-A verified room 313 had urine odor in the room. H-A stated there was new flooring placed in the room about three months ago. H-A stated the flooring was replaced because the tile in room was old and the urine would seep into the floor. H-A stated she cleaned the floor in room 313 once a day and used bactizyme (floor cleaner) to clean the floor in the room to help eliminate the urine odor. H-A verified the urine odor continued to be a problem and had been an ongoing problem since R129 was admitted to the facility. During an interview on 5/8/14 at 11:54 a.m. the director of housekeeping (DOH) verified room 313 had a strong urine odor. DOH stated R129 urinated on the floor and would not use the guard on the commode and stated staff has tried to	F 253	on a more frequent basis in resident room and bathroom. Dirty clothing is being removed when found in the hamper and sent for laundering. Care plan was updated to alert staff of history of strong urine odors. Housekeeping Manager or their designee are responsible for monitoring of this plan of correction. Completion Date: 6/18/14	

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	245233	A. BUILDING _____ B. WING _____	05/09/2014

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F 253	Continued From page 13 encourage him to sit down to urinate, but he preferred to stand. The DOH stated housekeeping, " does a once a day cleaning with a urine neutralizer, a chemical cleaner that breaks down the urine crystals to eliminate the odor. " The DOH stated the flooring was changed in room 313 as R129, " had peed so much on the floor we could not get the odor out and before the flooring company would lay the new floor they wanted the facility to treat the floor for the urine smell. " The DOH stated when the new flooring was placed in room 313 the decision was made to have the vinyl go up around the wall and cocking was placed around toilet to help prevent the urine from soaking into the floor. The DOH stated housekeeping was to clean the floor once a day and nursing staff was to clean the floor when they noticed any urine on the floor. During an environmental tour on 5/8/14 at 12:04 p.m. the director of housekeeping verified the strong urine odor present in room 313. The DOH verified the current plan to manage the urine odor in room 313 was not effective. A housekeeping policy for cleaning resident rooms was requested and not provided.	F 253		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	F 315		6/18/14

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F 315	Continued From page 14 infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide justification for use of a prophylactic antibiotic medication for 1 of 1 residents (R163) reviewed for unnecessary medications. Findings Include: R163 had been admitted on 4/18/14. R163's physician orders dated 4/14/14, identified diagnoses that included but not limited to history urinary tract infection, prophylactic treatment measures and hypertonicity bladder. The admission Minimum Data Set (MDS) dated 4/24/2014, indicated R163 brief interview of mental status (BIMS) had been 4 out of 15 on the MDS and indicated severe cognitive impairment and had received antibiotic medication. During review of R163's current physician orders dated 4/14/14, revealed an order for nitrofurantoin monohydrate/macrocrystals (nitrofurantoin) (an antibiotic medication) 100 milligrams (mg) once a day for history urinary tract infection. R163's physician progress note dated 5/1/14, had no documentation regarding use of prophylactic antibiotic and history of urinary tract infection. During review of R163's care plan dated 4/18/14, identified problem of recurring urinary tract infections due to conditions: female have short urethras increasing risk, menopause causing	F 315	F315 SS = D Facility has systems in place to ensure the resident who enters the facility without an indwelling catheter is not catheterized unless the resident□s clinical condition demonstrated that catheterization was necessary and resident has a diagnosis to support; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Facility policy of Prophylactic Antibiotic Use was written. Licensed Nurses will review the policy. R163 has proper documentation for the use of a prophylactic antibiotic. Director of Nursing or their designee are responsible for monitoring of this plan of correction. Completion Date: 6/18/14	

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F 315	Continued From page 15 decreased levels of estrogen which thins walls of urinary tract reducing ability to resist bacteria. Interventions included monitor temp weekly, encourage fluids with meals, med passes, with toileting and with snacks between meals, toilet every two hours and pericare with each void wiping front to back, will continue receiving showers versus a tub bath and cranberry tabs (R163's physician orders dated 4/14/14 had no order for cranberry tabs and R163's medication administration record's dated 4/18/14 through 5/9/14, revealed no cranberry tabs had been administered). R163's care area assessment summary (CAA's) dated 4/30/14, had no documentation regarding history of urinary tract infections and use of prophylactic antibiotic. During review of R163's administration record dated 4/18/14 through 5/9/14, identified R163 had received nitrofurantoin macrocrystals daily per physician orders since admission. During interview on 5/9/14, at 12:33 p.m., director of nursing stated she would expect physician to address use of antibiotic, especially if used as prophylactic. Director of nursing verified R163's record had no documented justification for use of prophylactic antibiotic.	F 315		

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	245233	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/07/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY 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, Saint Anne Extended Healthcare Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 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	K 000	EPOC	

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

Electronically Signed | 05/27/2014

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

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Saint Anne Extended Healthcare Center is a 6-story building with no basement. The facility was constructed in 1962 and was determined to be of Type II(222) construction. The facility is fully sprinkled and has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 109 beds and had a census of 99 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 020 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings	K 020		6/30/14

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K 020	Continued From page 2 between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide proper enclosed vertical openings as per 2000 NFPA 101, sections 19.3.1.1 and 8.2.5.6. This deficient practice could affect 48 out of 99 residents Findings include: On facility tour between 9:30 AM and 12:30 PM on 05/07/2014, observation revealed, that in the 5th floor storage room # 509, there are penetration around the entire 4 inch conduit going through the floor and ceiling assembly. This creates a vertical shaft that does not have fire separation between floors. NOTE: Check all floors where this conduit penetrates the floor and ceiling assemblies. This deficient practice was confirmed by the Facility Maintenance Director (TS) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 020	Gaps around the conduit will be filled with 3M fire barrier rated foam, FIP-1 at a rate of 4 1/2 inches to obtain UL listed 2 hour rating. This work will be completed by Alltrades Service LLC on or before 6/30/14. Director of Maintenance or their designee are responsible for monitoring of this plan of correction.	