

Electronically delivered August 25, 2021

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

RE: CCN: 245233

Cycle Start Date: June 11, 2021

Dear Administrator:

On July 2, 2021, we notified you a remedy was imposed. On August 18, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 12, 2021.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective July 17, 2021 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of July 2, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 11, 2021. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us



Electronically delivered

August 25, 2021

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

Re: Reinspection Results

Event ID: XF4H12

Dear Administrator:

On August 18, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 11, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us



Electronically Submitted July 2, 2021

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

RE: CCN: 245233

Cycle Start Date: June 11, 2021

#### Dear Administrator:

On June 11, 2021, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

#### REMOVAL OF IMMEDIATE JEOPARDY

On June 11, 2021, the situation of immediate jeopardy to potential health and safety cited at F0689 was removed. However, continued non-compliance remains at the lower scope and severity of D.

#### **REMEDIES**

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

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 17, 2021.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

Saint Anne Extended Healthcare July 2, 2021 Page 2

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 17, 2021, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 17, 2021, (42 CFR 488.417 (b)).

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

### SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Saint Anne Extended Healthcare is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 11, 2021. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

### ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of

Saint Anne Extended Healthcare July 2, 2021 Page 3

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

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

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

### **DEPARTMENT CONTACT**

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

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

Office: (507) 206-2727 Mobile: (507) 461-9125

### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

Saint Anne Extended Healthcare July 2, 2021 Page 4 verification.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 11, 2021 (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.

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

### APPEAL RIGHTS DENIAL OF PAYMENT

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

### Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.

Saint Anne Extended Healthcare July 2, 2021 Page 5

> Cohen Building – Room G-644 Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

### APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

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

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

Saint Anne Extended Healthcare July 2, 2021 Page 6

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/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: <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>

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.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

M. Pais

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

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

PRINTED: 07/07/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	COM	E SURVEY PLETED
		245233	B. WING				C <b>11/2021</b>
	PROVIDER OR SUPPLIER  NNE EXTENDED HEA	ALTHCARE		1347	EET ADDRESS, CITY, STATE, ZIP CODE 7 WEST BROADWAY IONA, MN 55987	,	
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F 000	INITIAL COMMEN		F 0	000			
	survey was conduct was found to be NO requirements of 42 Requirements for L.  The following compound of the survey resulted (IJ) when the facility implement intervent of 3 residents (R). The IJ began on 6/exited the unsecure main floor to the outpacility unattended administrator and conotified of the IJ on was removed on 6/12.	d in an Immediate Jeopardy failed to assess and stions to prevent elopement for 1 reviewed for elopement. 5/21 at 8:41 a.m., when R1 ad door, exited the door on the atdoors and walked around the by staff. The facility director of nursing (DON) were 6/11/21 at 9:19 a.m. The IJ 1/11/21 at 4:37 p.m. when the					
	reoccurrence.  The above findings quality of care, and conducted on 6/11/ The facility's plan of as your allegation of Departments acceptions.  Because you are esignature is not recopage of the CMS-2	of correction (POC) will serve of compliance upon the otance.  nrolled in ePOC, your quired at the bottom of the first 1567 form. Your electronic POC will be used as					
LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE

Electronically Signed 07/06/2021

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.

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE S COMPL	
		245233	B. WING _		C <b>06/11/2021</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  1347 WEST BROADWAY  WINONA, MN 55987	1 00/1	1/2021
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F 000	an onsite revisit of to validate substan- regulations has bee	acceptable electronic POC, your facility may be conducted tial compliance with the en attained.	F 00			7/40/04
F 689 SS=J	CFR(s): 483.25(d)( §483.25(d) Accider The facility must er §483.25(d)(1) The as free of accident §483.25(d)(2)Each supervision and as accidents. This REQUIREMEI by: Based on observareview, the facility frisk of elopement for equipped with secun wander guard) who unalarmed exit door resulted in an Immer exited the building doors. This practic other residents who devices in place at residents (R3 and Interested the 4th floor unsecured exit door around the building with out being notice and director of nurse	nts. resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent  NT is not met as evidenced tion, interview and document failed to identify an increased or 1 of 3 (R1) residents writy safety alarm devices (aka. The facility's failure rediate Jeopardy (IJ) when R1 unnoticed through unsecured the had the potential to affect to had wander guard system the time of survey for 2 of 2	F 68	Facility has systems in place to en residents are free of accident haza are supervised and elopement dev are working properly.  (R1) was transferred to the secured memory care unit on 6/5/21 and has safety checks implemented immed (R3 & R4) elopement risk assessme were completed by 6/11/21.  Facility policies related to Missing Resident, Potential for Elopement, Wanderguard placement procedure were reviewed with licensed nursing and included education on checking functionality of the wanderguard bracelets. All maintenance staff we educated on the functionality of the wanderguard sensor equipment. A	nsure urds, rices  d ad liately. nents  and es ng staff ng the ere	7/12/21

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

		COM	B) DATE SURVEY COMPLETED				
		245233	B. WING _			C <b>06/11/2021</b>	
	PROVIDER OR SUPPLIER	ALTHCARE		STREET ADDRESS, CITY, STATE, ZIP 1347 WEST BROADWAY WINONA, MN 55987	•		
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F 689	on 6/11/21, at 4:37 remained at the low D - isolated, scope indicated no actual than minimal harm jeopardy.  Findings include:  R1's admission Min assessment dated cognitive impairmed wandering 1-3 day 1 with dressing and with all other activiticane/walker for more wandering to a complete the complete that impaired safety award place with interven placement right will document incidents activities, structure wandering by offer safe place to wand R1's facility reported dated 6/5/21 at 10: received call from a was said to be four wander guard in plof incident.  R1's progress note included, writer received call from a was said to be four wander guard in plof incident.	p.m. but noncompliance wer scope and severity level of and severity level, which harm with potential for more that is not immediate  nimum Data Set (MDS) 3/22/21, indicated severe nt, rejection of cares daily, s, required extensive assist of d transfers, limited assist of 1 ties of daily living, and used a obility.  ed 3/30/21, included: at risk for ent by history of attempts to ended, wander aimlessly, areness and disoriented to tions to check wander guard ist and function every shift, s of wandering, encourage d daily routine, distract from ing diversions, and provide	F 68	nursing staff were reeducate reporting any malfunctioning the nurse, ED, DON. All ecompleted as noted in the plan.  All Elopement risk assessing completed/reviewed upon quarterly, annually and wit significant change in cognany wanderguard braceled time five, will be checked from any time. Treatment Admin Record.  As outlined in the 2567, Elstop sign across exit door stairwell and installed an at that alerts staff if the door any time. The alarm was at the time of the elopement DON or their designee will weekly audits to assure eleassessments are completed above.  Environmental Services Designee will review audits equipment on a weekly bacompliance.  Results of audit findings wat IDT meetings and at the Council meeting. Ongoing duration to be determined analysis and review of results and the review of results and review of re	ng equipment to education was abatement  ments will be admission, th any itive status. Its placed, at this for placement it via the inistration  D-A placed a on main floor in alarm system is opened at not on the door ent.  I perform opement risk ed as outlined  irector or their is of elopement is to ensure  will be discussed a facility Quality is frequency and through		

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

			COMI	E SURVEY PLETED			
		245233	B. WING			C <b>06/11/2021</b>	
	PROVIDER OR SUPPLIER  NNE EXTENDED HEA	LTHCARE		13	TREET ADDRESS, CITY, STATE, ZIP CODE 347 WEST BROADWAY /INONA, MN 55987		11/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Church stating R1 vand they took R1 to new shaver from WAnne's Extended H9:45 a.m.; R1 did nstated he was going shaver; writer educt safety and how he alone; wander guar alarms off on the melevators; for an intup to 5th floor for hwith the move and behind it; writer cor and updated him all incident and emerg for the update; DOI aware of the situati to transfer resident  During observation 9:15 a.m. R1's roor directly across from was a piece of pape code to exit]. DON inside sliding doors that exinclude the wander they believed R1 wand walked out the an alarm unnoticed guard was implement R1 wandering the head of the control of the piece of the wander they believed R1 wand walked out the an alarm unnoticed guard was implement R1 wandering the head of the piece of	was found to be over there of the lake and also got him a dalgreens; R1 returned to Saint ealthcare on to 4th floor at ot have any injuries and go to go and get himself a new ated R1 on the importance of shouldn't leave the building of is working and he set the ain entrance and 5th floor ervention resident was moved its safety; resident was okay understood the reasoning stacted his emergency contact fout the move and the ency contact thanked writer N was updated and made on and had made the decision to 5th floor for safety reasons.  and interview on 6/10/21, at m prior to the elopement was in the 4th floor stairwell. There are on the door that read [the stated on the main floor the eard lower floor where staff and have had wander guard DN stated the main entrance exits to outside does not guard alarm. DON indicated ent down four flights of stairs main door that did not have.  DON stated R1 wander ented 3/23/21 after observing halls.	F 6	89	Director of Nursing or their designer responsible for monitoring of this properties.  Completion Date: 7/12/21		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	NG		ATE SURVEY OMPLETED
		245233	B. WING _		0.0	C 6/ <b>11/2021</b>
	PROVIDER OR SUPPLIER	LTHCARE		STREET ADDRESS, CITY, STATE, ZIP COL 1347 WEST BROADWAY WINONA, MN 55987		57117 <b>2</b> 021
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F 689	down the halls seve staff assisted him a packed his bag and put on his coat but down and eat a sna to let him talk to hin calm R1; staff ambi with R1 and then stairwell door and stairwell door and set the door and needed was not sounding a attempt to open the exit the building; R1 towards exit doors on the elevator and guard will be check and functionality and treatment administrative record lacked assessment being overbal comments of placement of the was a 1,24/2021, at 1:53 hit button; Houseked attempting to open unsuccessfully ther stated he was going the state of the state of the was going the state of the state of the was going the state of the was going the state of the was going the state of the state of the state of the was going the state of the sta	B p.m. R1 had been up and eral times transferring himself; nd sat 1:1 with him; R1 then I insisted he was leaving and was then agreeable to sit ack first; writer called his friend in but unfortunately this did not ulated up and down hall again ated he wanted to watch TV.  a.m. R1 was observed corner from the North stated he heard someone at ed to check; and door alarm and it appeared he did not edoor.  p.m. wander guard was wrist to alert staff if he were to I has wandered down the hall as well as speaking of getting going shopping; wander ed each shift for performance and documented in the eation record.  an updated elopement risk completed after attempts, f wanting to leave or the ander guard.  p.m. R1 came to elevator and seping staff noted him	F 6	89		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  IG	CON	TE SURVEY MPLETED
		245233	B. WING _			C / <b>11/2021</b>
	PROVIDER OR SUPPLIER  NNE EXTENDED HEA	LTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1347 WEST BROADWAY WINONA, MN 55987		
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F 689	returned to room are everything packed  -3/27/2021, 3:33 p. R1 getting onto the bags packed; writer became very upset the elevator toward sign so turned around returning to stating we were "ket -3/29/2021, at 8:57 had taken elevator down to ground floof floor by staff; R1 was later notice suitcase; R1 stated was redirected bacc -6/03/2021, at 2:06 1st floor for another arrive with restorative staff staffoor and had stated restorative staff room to church service a outside for a walk; and receptionist co get R1.	m., included an observation of elevator with his coat on and requickly intervened. R1 with writer and stormed out of s stairwell. and noted the stopend and stormed past elevator, ghly out of the way and turned elevator; R1 angry with staff eeping him against his will"  p.m. reception called and R1 down to first floor then went or but was brought back to 4th as initially resistive to returning intually cooperative; R1 had and had brought this with him; indicated and the wanted to leave but he k to his room.  p.m. the social worker was on a matter and observed R1 we staff from the elevator; the she found R1 on the 2nd of he was going to the chapel; the elevator to 1st floor with R1; and R1 stated he wanted to go social worker walked with R1 intacted 4th floor staff to come		39		

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245233	B. WING			C / <b>11/2021</b>	
	PROVIDER OR SUPPLIER  NNE EXTENDED HEA	LTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1347 WEST BROADWAY WINONA, MN 55987		11/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 689	-6/04/2021, at 4:55 agitated and had hi to get on elevator to assisted to redirect staircase in which he door to open; R1 the to his room and cal after the nurse recestating R1 had called they wanted to make During an observat at 10:06 a.m., R1 he facility and going get his razor. R1 the facility for about a viscomeone with him in During an interview DON stated there he elopement from facts atted elopement acompleted upon ad DON stated the teat concerns daily included perment for resident During an interview registered nurse (R statements of want on the main floor. Fix was implemented to were to escort R1 cattend church or other was not a warron to other was not a warron to other was not a warron to open the redirect of the statements of warron to the was not a warron to open the statements of warron the was not a warron to open the statements of warron the was not a warron to open the statements of warron to the warron to other was not a warron to open the statements of warron to the warron to the statements of warron to	p.m. R1 became more s bag packed and was trying o get to his car; 3 staff; R1 then moved towards the ne was not able to put code for en told staff he would return I someone to help and shortly gived a call from receptionist ed 911 asking for help and se sure everything was ok.  ion and interview on 6/10/21 and no recollection of leaving g to the church next door to ought he had only lived at the week and stated he needs in order to go outside now.  on 6/10/21 at 10:17 a.m., and not been other incidents of sility for other residents. DON ssessment should be mission, quarterly, and yearly, and discusses behavior adding if wandering or ents.  on 6/10/21 at 10:33 a.m., and not be an adding or ents.  on 6/10/21 at 10:33 a.m., and stated the wander guard live to the statements and staff off floor using elevator to the activities. RN-B stated ander guard alarm system at r and only one at main	F 6	89			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		CON	COMPLETED			
		245233	B. WING _			C / <b>11/2021</b>
	PROVIDER OR SUPPLIER  NNE EXTENDED HEA	LTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODI 1347 WEST BROADWAY WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 689	During an interview LPN-B stated she welopement. LPN-B call from one of the know R1 was there know he was missi notified facility that LPN-B stated R1 hwas uncertain if it suilding. LPN-B stated she was not elopements for R1 LPN-B stated R1 would check of used elevator a confound on main floor leave the building awas now on the set stated no other resulting an interview RN-C stated he would check of the building awas now on the set stated no other resulting an interview RN-C stated he would check of the building awas now on the set stated no other resulting an interview RN-C stated he would had last notice solarium. RN-C refused at the next downs not aware R1 stated no alarms haven R1 returned in notified the DON are stated R1 likely too level when he left to	on 6/10/21, at 10:54 a.m. was working day of R1's said staff received a phone local churches letting them L LPN-B stated staff did not ng until the church staff R1 was there with them. ad his wander guard on and ounded when he left the hid R1 had taken the elevator initored frequently. LPN-B aware of any other and others in the facility.	F 68			

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245233	B. WING	B. WING		C / <b>11/2021</b>	
	PROVIDER OR SUPPLIER	LTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1347 WEST BROADWAY WINONA, MN 55987		11/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 689	alarms. RN-C state had not been exit s directed. RN-C state other incidents of e RN-C stated R1 was floor upon return to During an interview Social worker (SW) assessment was con R1 on 3/17/21 and elopement risk assettime. SW-A stated I sit in the solarium at the facility impleme R1. SW-A stated or elevator with a restrindicated he wanted time there was no content of R1 then wanted to outside and had the come and take him stated the restoration R1 on the 2nd floor 1st floor. SW-A stated allarm when taking outside. SW-A stated allarm when taking outside. SW-A stated all doors to sand there was a was the main floor doors entrance. SW-A stated wander guard alarm not on 3rd or 4th flomoved to the securing stated.	ed R1 was independent and eeking and was easily ted there had not been any lopement for R1 or others. Is moved to secure unit on 5th facility.  I on 6/10/21, at 12:20 p.m., -A stated an elopement risk ompleted upon admission for had not had another essment completed since that R1 would pack his bags and and began to wander more so nted a wander guard band for a 6/3/21, she saw R1 exit off orative staff and R1 had at to go to church but at that church services. SW-A stated go outside so she took him exceptionist call for staff to back to 4th floor. SW-A we aide had stated she found and brought him down to the led his wander guard did R1 through main doors to ed there was discussion with on to increase time with	F 6	89			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION  IG	COM	E SURVEY IPLETED
		245233	B. WING _			C <b>11/2021</b>
	PROVIDER OR SUPPLIER  NNE EXTENDED HEA	LTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1347 WEST BROADWAY WINONA, MN 55987		11/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 689	floor, whether it was but assumed he took the facility cameras 8:41 a.m. though R on floor around 9:0 not been able to disperson who found I notified the facility at they were taking R purchase a razor a SW-A stated R1 was 9:45 a.m. SW-A fur 4th floor from 5th florelating to elopeme wander guard in plateave the unit. SW-if R4 exited floor us to leave the building would alarm.  During an interview administrator on 6/stated R1 was not since first implementad not been assess the current year or the code to the exit 4th floor. DON state using elevator befoleave the facility. Dresidents who requiplacement had been have been. DON scompleted the elop stated any new administration and been stated any new administration been stated any new administration been stated any new administration been assessed the current year or the code to the exit 4th floor. DON state using elevator befoleave the facility. Dresidents who requiplacement had been administration and been as yellow the elop stated any new administration been as yellow the facility. Dresidents who requiplacement had been and yellow the elop stated any new administration been as yellow the facility.	y knew how R1 left the 4th st the stairwell or the elevator, ok the elevator. SW-A stated is showed R1 exiting building at N-C stated R1 was last seen 0 a.m. SW-A stated they had scuss the incident with the R1. SW-A stated the person around 9:30 a.m. and stated 1 to nearby Walgreens to s R1 was requesting a razor. as returned to the facility at ther stated R4 was moved to poor, due to an incident not ant, but continued to have the face and had not attempted to A stated staff would not know sing elevator, but if attempted g the wander guard alarm	F 68			

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

	N OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245233	B. WING			C / <b>11/2021</b>
	PROVIDER OR SUPPLIER	LTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1347 WEST BROADWAY WINONA, MN 55987	1 00/	711/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 689	the facility cameras through the stairwe 8:41 a.m. and was side of building at 8 stated the elevator show R1 exiting the the exit in the stairw had taken the stairs elevator to bottom from bottom floor at exit door at main le administrator stated accurate. DON sta and bottom floor was he was alerted by notification that R1 door. The administr fourth floors do not yet and verified the each floor who requipard.  During an interview environmental direct current wander guard and the facility had the past to add alar building. ED-A stat requested quotes frupdating the system stairwell exit on ma currently and could or bottom floor with main floor from the stairwell the doors a from inside the stair	and R1 exit the building at last seen on camera on east 3:44 a.m. The administrator camera on main floor did not elevator at any time prior to well leaving them to believe R1 from 4th floor or took floor and entered stairwell and climbed the stairs to the vel in the stairwell. The did the camera times were ted the stairwell on main floor as used by staff. DON stated staff at 9:23 a.m. of the was found at the church next rator stated the third and have wander guard alarms facility had one resident on uired the use of the wander.  Ton 6/10/21 at 2:33 p.m., ctor (ED)-A stated he felt the ard alarm system was obsolete checked into a new system in ms in other areas of the ed he had not recently from other companies for in. ED-A confirmed the in floor was not alarmed be accessed from main floor out code. ED-A stated on vestibule entering the are locked but if your coming rewell into the vestibule to exit door in not locked or alarmed.	F 6	89		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  IG	CON	TE SURVEY MPLETED
		245233	B. WING _			C / <b>11/2021</b>
	PROVIDER OR SUPPLIER	LTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1347 WEST BROADWAY WINONA, MN 55987		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	church staff-A state church on Saturday staff were present to could not verify the stated the [person] currently on vacation indicated the [person] currently on vacation indicated the [person] event location and facility to notify they a razor R1 was insistated the parishion. The church staff-A police officers in are indicating if the facinate him and will be buring an interview. DON stated they were viewing and compassessments of all and would be finish of having those result and would be finish of having those result into the key stairwells. Our plant wireless and get a with that company obsolete. The DON residents with wand to leave the facility. During an observat at 2:35 p.m., ED-A sign across exit do and installing an also	on 6/10/21 at 2:43 p.m., the of no one is usually at the sys but due to an event some that day. The church staff-A time R1 had shown up and who was with R1 was on. The church staff-A on] took R1 with him to the that a parishioner called the staff. The church staff-A then her returned R1 to the facility. Stated there were a couple of ea that the staff alerted them lity reports R1 missing they be bringing him back.  To on 6/10/21 at 3:00 pm., the ere currently in the process of pleting elopement residents with wander guards on ors screened to see if they and know what year it is to pad and get out into the was to reach out to Advanced new wander guard system as the current company is also stated the other der guards had not attempted	F 68			

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245233	B. WING			C 06/11/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST 1347 WEST BROADWAY WINONA, MN 55987	•	00/11/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 689	he will also be instate east exit door from  The immediate jeory was removed on 6/secured unalarmed documentation and residents, elopemedementia, but the number of the lower scope and which indicated no more than minimal jeopardy because the elopement risk and exhibited signs of elof of wander guards.  Facility policy Poter 3/26/08 and review wander guard is a siff a resident leaves wander guard alarm. The procedure incluenvironment for residents and ensure that the maintain safety with through identifying upon admission, quisignificant change if applying wander guexhibit exit seeking ability to leave the fimplemented including residents the residents currer and analysis of haz makes attempts to	alling the same alarm on the building.  Deardy that began on 6/5/21, 11/21, when the facility doors, supplied educated all staff on missing int, wander guard alarms and oncompliance remained at diseverity level of D - isolated, actual harm with potential for harm that is not immediate the facility failed to identity an reassess residents who lopement and continued use of afe alternative that alerts staff a unit or the facility where a in system is in place. Ided: provide a safe idents who are exit seeking by are in secure location to nout leaving the facility residents at risk of elopement larterly, annually and with in condition and through lard bracelet for residents that tendencies and that have the	F 6	89		

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

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		COMPLETED			
		245233	B. WING			C / <b>11/2021</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1347 WEST BROADWAY WINONA, MN 55987	1 00	11/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRIES OF THE A	ILD BE	(X5) COMPLETION DATE
F 689	individualized resid such as adequate striggers related to a for effectiveness of tracking related to a testing the wander alarms will only soumain entrance, and resident on a floor of wander guard further implemented to assist the unit or all attem	ent centered interventions supervision and monitoring for attempting to elope, monitoring interventions, behavior attempts to leave building, guard each shift, notification and on 5th and 2nd floor, the ground floor entrance, if a other than 5th or 2nd has a er supervision will need to be sure resident does not leave pts will be made to move the are unit if room is available.	F6	89		



Electronically delivered July 2, 2021

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

Re: State Nursing Home Licensing Orders

Event ID: XF4H11

#### Dear Administrator:

The above facility was surveyed on June 10, 2021 through June 11, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04</a> 8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Saint Anne Extended Healthcare July 2, 2021 Page 2

the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

Office: (507) 206-2727 Mobile: (507) 461-9125

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please 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.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		00955	B. WING		06/1	1/2021
	PROVIDER OR SUPPLIER	1347 WFS	DRESS, CITY, S BT BROADW	STATE, ZIP CODE AY		
SAINT A	NNE EXTENDED HEA	I THCARE	MN 55987	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000 Initial Comments		2 000				
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre pursuant to a surve found that the defic herein are not corre not corrected shall	Minnesota Statute, section ction order has been issued by. If, upon reinspection, it is ciency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of artment of Health.				
	corrected requires requirements of the number and MN Ru When a rule contain comply with any of lack of compliance re-inspection with a result in the assess	hether a violation has been compliance with all erule provided at the tagule number indicated below. It is several items, failure to the items will be considered. Lack of compliance upon any item of multi-part rule will sment of a fine even if the item uring the initial inspection was				
	that may result from orders provided that the Department wit	hearing on any assessments in non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	conducted at your to Minnesota Departing facility was found to the MN State Licent electronic plan of conducted the MN state.	TS: 1/21, a complaint survey was facility by surveyors from the nent of Health (MDH). Your to be NOT in compliance with asure. Please indicate in your orrection you have reviewed dentify the date when they will				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 07/06/21

STATE FORM 6899 If continuation sheet 1 of 15 XF4H11

TITLE

(X6) DATE

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00955	B. WING		06/1	) 1/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
I SAINT ANNE EXTENDED HEAI THCARE			T BROADW	AY		
	OUR MARRY OTA	TEMENT OF DEFICIENCIES	MN 55987	DDOLUDEDIO DI AMI OF CODDECTI	211	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOUL  CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 000 Continued From page 1		2 000				
	be completed.					
	The following comp SUBSTANTIATED: a licensing order is Minnesota Departn the State Licensing Federal software. The state state of the State Licensing Federal software. The state of the findings of the correction order the findings which a statute after the state of the findings which a statute after the state of the Minnesota Department of State licenthe Minnesota Department of Head you electronically. It is necessary for State licenthe word "CO available for text. Yelectronic State licenthe Minnesota Department of Head you electronically. It is necessary for State licenthe word "CO available for text. Yelectronic State licenthe Minnesota Department of Head you electronic Minnesota Department of Head you electronic Minnesota Department of	nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for the assigned tag number eft column entitled "ID Prefix attute/rule out of compliance is the "To Comply" portion of the state are in violation of the state attement, "This Rule is not met collowing the surveyor 's aggested Method of Correction or Correction. To participate in the electronic ansure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf elicensing orders are				

6899

Minnesota Department of Health STATE FORM

XF4H11 If continuation sheet 2 of 15

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY LETED	
		00955	B. WING		06/1	C 1/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
CAINT A	NNE EXTENDED HEA	1347 WF	ST BROADW			
SAINTA	NNE EXTENDED HEA	WINONA	, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE I WHICH STATES, IN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			7/12/21
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des and 4658.0405. At be out of bed as muis a written order from the custodian from the cu	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 nursing home resident must uch as possible unless there om the attending physician ust remain in bed or the remain in bed.				
	by: Based on observation review, the facility for its of elopement for equipped with secun wander guard) who unalarmed exit door resulted in an Immediate the building of doors. This practic other residents who	ent is not met as evidenced on, interview and document ailed to identify an increased or 1 of 3 (R1) residents rity safety alarm devices (aka. exited the building through rs. The facility's failure ediate Jeopardy (IJ) when R1 unnoticed through unsecured e had the potential to affect o had wander guard system the time of survey for 2 of 2 R4).		corrected		

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION ( A. BUILDING:			SURVEY LETED	
		00955 B. WING			C <b>06/11/2021</b>	
NAME OF I	PROVIDER OR SUPPLIER			TATE, ZIP CODE	1 06/1	1/2021
		1347 WFS	ST BROADW			
SAINT A	NNE EXTENDED HEA	LTHCARE 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 SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 3	2 830			
	exited the 4th floor unsecured exit doo around the building with out being notic and director of nurs IJ on 6/11/21, at 09 on 6/11/21, at 4:37 remained at the lov D - isolated, scope indicated no actual than minimal harm jeopardy.	5/21, at 08:41 a.m. when R1 and into a stairwell through an r to the main floor and walked outdoors to a nearby church ed. The facility administrator sing (DON) were notified of the :19 a.m. The IJ was removed p.m. but noncompliance wer scope and severity level of and severity level, which harm with potential for more that is not immediate				
	Findings include:					
	R1's admission Minimum Data Set (MDS) assessment dated 3/22/21, indicated severe cognitive impairment, rejection of cares daily, wandering 1-3 days, required extensive assist of 1 with dressing and transfers, limited assist of 1 with all other activities of daily living, and used a cane/walker for mobility.					
	elopement as evide leave facility unatte impaired safety aw place with intervent placement right wri document incidents activities, structured wandering by offeri safe place to wand R1's facility reported dated 6/5/21 at 10:	ed 3/30/21, included: at risk for ent by history of attempts to inded, wander aimlessly, areness and disoriented to tions to check wander guard at and function every shift, of wandering, encourage didaily routine, distract from ing diversions, and provide er.  d incident to State agency 11 a.m. indicated facility eceptionist stating that R1				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
				A. BUILDING:		С	
		00955		B. WING			1/2021
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SAINT A	NNE EXTENDED HEA	LTHCARE		ST BROADW MN 55987	AY		
(X4) ID PREFIX TAG		TEMENT OF DEFICION  MUST BE PRECEDING INF	ENCIES ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 4		2 830			
	was said to be found at [name] church and wander guard in place was working before time of incident.						
	R1's progress note included, writer rec stating that they go Church stating R1 vand they took R1 to new shaver from WAnne's Extended H9:45 a.m.; R1 did n stated he was going shaver; writer educ safety and how he alone; wander guar alarms off on the melevators; for an intup to 5th floor for h with the move and behind it; writer cor and updated him all incident and emerg for the update; DOI aware of the situati to transfer resident  During observation 9:15 a.m. R1's roor directly across from was a piece of pape code to exit]. DON inside sliding door a enter were locked a	eived a call from the ta call from the was found to be the lake and all algreens; R1 relealthcare on to thave any injugito go and get ated R1 on the shouldn't leave at its safety; reside understood the stacted his emerout the move a ency contact the N was updated at to 5th floor for stated on the door the stated on the mand lower floor wand have had wand have had wand have had we had we had a stated on the mand lower floor wand have had we had a stated on the mand lower floor wand have had we h	n receptionist [Name] e over there lso got him a eturned to Saint 4th floor at uries and himself a new importance of the building d he set the nd 5th floor ent was moved ent was okay reasoning rgency contact and the anked writer and made de the decision safety reasons. on 6/10/21, at opement was rairwell. There hat read [the nain floor the where staff ander guard				
	alarms in place. DO sliding doors that e include the wander they believed R1 w and walked out the	exits to outside o guard alarm.  C ent down four fl	does not OON indicated ights of stairs				

Minnesota Department of Health STATE FORM

KF4H11 If continuation sheet 5 of 15

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		o. ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00955	B. WING	G		06/1	) 1/2021
	PROVIDER OR SUPPLIER  NNE EXTENDED HEA	I THCARE	REET ADDRESS, 0 47 WEST BRO NONA, MN 55	ADWA			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ΞIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	an alarm unnoticed guard was implement R1 wandering the half was not sound to let him talk to him calm R1; staff ambut with R1 and then stairwell door and stairwell door and stairwell door and stairwell door and seat was not sounding a attempt to open the half wander was not sounding a attempt to open the was not sounding a attempt to open the was not sounding; R1 towards exit doors on the elevator and guard will be check and functionality and treatment administration of the was not soundered was not sounding; R1 towards exit doors on the elevator and guard will be check and functionality and treatment administration of the wander was not soundered was not sounding; R1 towards exit doors on the elevator and guard will be check and functionality and treatment administration of the wander was not soundered was not sound the stairwell was not sound the stairw	DON stated R1 wander and 3/23/21 after observables.  gress notes from 3/19/2 following:  gp.m. R1 had been up a great times transferring him has at 1:1 with him; R1 to a line in the attention and the was leaving was then agreeable to suck first; writer called his in but unfortunately this coulated up and down hall atted he wanted to watch a.m. R1 was observed corner from the North tated he heard someone and it appeared he did not a door.  p.m. wander guard was wrist to alert staff if he was wandered down the as well as speaking of groing shopping; wandered each shift for performed documented in the attention record.  an updated elopement recompleted after attempts from the leave or the	oving  I to  I to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00955	B. WING			C <b>11/2021</b>
	PROVIDER OR SUPPLIER  NNE EXTENDED HEA	ITHCARE 1347	ET ADDRESS, CITY, WEST BROADV DNA, MN 55987			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 830	hit button; Houseke attempting to open unsuccessfully ther stated he was going shaver; redirected or returned to room ar everything packed:  -3/27/2021, 3:33 p.IR getting onto the bags packed; writer became very upset the elevator toward sign so turned aroupushed divider rougaround returning to stating we were "ket-3/29/2021, at 8:57 had taken elevator down to ground floof floor by staff; R1 was to unit but was ever packed suitcase an R1 was later notice suitcase; R1 stated was redirected backet with restorative with restorative staff staffloor and had stated restorative staff rod no church service a outside for a walk; staffloor and walk	seping staff noted him door on stairwell went towards elevator; R g to go home and get his put to solarium to monitor; and remained to have up and ready to go.  In the intervence of the interv	n of and att of stop ator, ned aff R1 att 4th aing d an; at so on and all; R1; o go R1			

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XF4H11 If continuation sheet 7 of 15

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
				A. BUILDING:			,
		00955		B. WING			1/2021
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SAINT A	NNE EXTENDED HEA	LTHCARE		ST BROADW MN 55987	AY		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 7		2 830			
	-6/03/2021, at 4:31 p.m. R1 was attempting to get on the elevator to get to the car; R1 stated his razor was in his car.						
	-6/04/2021, at 4:55 agitated and had hi to get on elevator to assisted to redirect staircase in which had oor to open; R1 th to his room and call after the nurse recestating R1 had called they wanted to make	s bag packed or get to his can get t	and was trying r; 3 staff red towards the le to put code for e would return help and shortly or receptionist for help and				
	During an observation and interview on 6/10/21 at 10:06 a.m., R1 had no recollection of leaving the facility and going to the church next door to get his razor. R1 thought he had only lived at the facility for about a week and stated he needs someone with him in order to go outside now.						
	During an interview DON stated there helopement from fact stated elopement a completed upon ad DON stated the teat concerns daily inclu- elopement for reside	ad not been of ility for other ressessment sh mission, quar m discusses luding if wande	other incidents of residents. DON nould be terly, and yearly. behavior				
	During an interview registered nurse (R statements of want on the main floor. F was implemented of were to escort R1 of attend church or other was not a ware	N)-B stated R ing to go to ch RN-B stated th lue to the state off floor using oner activities.	A1 had made nurch which was be wander guard ements and staff elevator to RN-B stated				

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AND PLAN OF CORRECTION IDENTIFICATION NOMBER.  A. BUILDING:	COMPLETED
· · · · · · · · · · · · · · · · · · ·	
00955 B. WING	C 06/11/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
SAINT ANNE EXTENDED HEALTHCARE  1347 WEST BROADWAY WINONA, MN 55987	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CO	ER'S PLAN OF CORRECTION (X5) RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETE DATE
elevator on 4th floor and only one at main entrance and lower floor entrance.  During an interview on 6/10/21, at 10:54 a.m. LPN-B stated she was working day of R1's elopement. LPN-B said staff received a phone call from one of the local churches letting them know R1 was there. LPN-B stated staff did not know he was missing until the church staff notified facility that R1 was there with them. LPN-B stated R1 had his wander guard on and was uncertain if it sounded when he left the building. LPN-B said R1 had taken the elevator before and was monitored frequently. LPN-B stated she was not aware of any other elopements for R1 and others in the facility. LPN-B stated R1 was moved to secure unit on 5th floor upon return to facility.  During an interview on 6/10/21, at 11:08 a.m., NA-A stated R1 was independent in room? and staff would check on him. NA-A stated R1 had used elevator a couple months ago and was found on main floor but had not attempted to leave the building at that time. NA-A stated R1 was now on the secure unit on 5th floor. NA-A stated no other residents had attempted to elope.  During an interview on 6/10/21, at 12:09 p.m., RN-C stated he worked 4th floor day of incident and had last noticed R1 around 9 a.m. near the solarium. RN-C received a phone call around 9:20 a.m. from the receptionist stating R1 was found at the next door church. RN-C stated he was not aware R1 had gone missing. RN-C stated he notified the DON and emergency contact. RN-C stated he notified the DON and emergency contact. RN-C stated N-C stat	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				С	
	00955	B. WING		06/1	1/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SAINT ANNE EXTENDED HE	AI THCARE	ST BROADW MN 55987	AY		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
elevators on 4th floalarms. RN-C state had not been exit stated. RN-C stated RN-C stated RN-C stated R1 will floor upon return to During an interview Social worker (SW assessment was created R1 on 3/17/21 and elopement risk assitime. SW-A stated sit in the solarium the facility implemed R1. SW-A stated of elevator with a resindicated he wanted time there was no R1 then wanted to outside and had the come and take him stated the restorated the restorated R1 on the 2nd flood 1st floor. SW-A stated alarm when taking outside. SW-A stated all doors to and there was a with emain floor door entrance. SW-A stated all doors to and there was a with emain floor door entrance. SW-A stated all doors to and there was a with emain floor door entrance. SW-A stated all doors to and the guard alar	he building. RN-C stated the por do not have wander guard ed R1 was independent and seeking and was easily ated there had not been any elopement for R1 or others. as moved to secure unit on 5th	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			7 ti Bolebiiro.			;
		00955	B. WING			1/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SAINT A	NNE EXTENDED HEA	I THCARE	ST BROADW MN 55987	AY		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
2 830	Continued From pa	ige 10	2 830			
	remains there on 3	0-minute checks. SW-A				
		y knew how R1 left the 4th				
		s the stairwell or the elevator, ok the elevator. SW-A stated				
		s showed R1 exiting building at				
		N-C stated R1 was last seen				
		0 a.m. SW-A stated they had				
		scuss the incident with the R1. SW-A stated the person				
		around 9:30 a.m. and stated				
	they were taking R1 to nearby Walgreens to purchase a razor as R1 was requesting a razor.					
	SW-A stated R1 was returned to the facility at					
		ther stated R4 was moved to oor, due to an incident not				
		ent, but continued to have the				
	wander guard in pla	ace and had not attempted to				
		A stated staff would not know				
	if R4 exited floor using elevator, but if attempted to leave the building the wander guard alarm would alarm.  During an interview with the DON and administrator on 6/10/21 at 2:05 p.m., DON stated R1 was not reassessed for elopement since first implemented 3/17/21. DON stated R1					
		ssed to determine if R1 knew				
	-	if R1 would be able to enter				
		door to the stairwell on the ed R1 had exited 4th floor				
		re but had never attempted to				
	leave the facility. D	ON stated she thought the				
		ired the wander guard				
		n reassessed and should stated the social worker				
	_					
	completed the elopement assessments and stated any new admissions with elopement risk					
	would ideally be ad	mitted to the secure unit on				
	5th floor. The adm	inistrator stated she reviewed				

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WIIIIIICGC	na Department of He	ailli				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
						,
		00055	B. WING			
		00955			1 00/1	1/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1347 WES	T BROADW	ΆΥ		
SAINT A	NNE EXTENDED HEA	LI HCARE WINONA,	MN 55987			
(V4) ID	SHMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	)N	(X5)
(X4) ID PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				DEFICIENCY)		
2 830	Continued From pa	ae 11	2 830			
	•					
		and R1 exit the building				
	•	Il exit then out of building at				
		last seen on camera on east				
	_	3:44 a.m. The administrator				
		camera on main floor did not				
	•	e elevator at any time prior to				
		vell leaving them to believe R1 s from 4th floor or took				
		loor and entered stairwell				
		nd climbed the stairs to the				
		vel in the stairwell. The				
		the camera times were				
		ted the stairwell on main floor				
		as used by staff. DON stated				
		staff at 9:23 a.m. of the				
		was found at the church next				
		rator stated the third and				
		have wander guard alarms				
		facility had one resident on				
	each floor who required the use of the wander guard.					
	guara.					
	During an interview	on 6/10/21 at 2:33 p.m.,				
		ctor (ED)-A stated he felt the				
		ard alarm system was obsolete				
		checked into a new system in				
	,	ms in other areas of the				
		ed he had not recently				
		om other companies for				
		n. ED-A confirmed the				
		in floor was not alarmed				
		be accessed from main floor				
	-	out code. ED-A stated on				
		vestibule entering the				
		are locked but if your coming				
		rwell into the vestibule to exit				
		door in not locked or alarmed.				
	During an interview	on 6/10/21 at 2:43 p.m., the				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00955	B. WING		C <b>06/11/2021</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SAINT A	NNE EXTENDED HEA	I THCARE	T BROADW MN 55987	AY		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	church staff-A state church on Saturday staff were present to could not verify the stated the [person] currently on vacation indicated the [person] event location and facility to notify they a razor R1 was instated the parishion. The church staff-A police officers in artindicating if the fact have him and will be described by the policy of having and compassessments of all and would be finish of having those resulting and would be finish of having those resulting and enter it into the key stairwells. Our plant Wireless and get a with that company obsolete. The DON residents with want to leave the facility. During an observation at 2:35 p.m., ED-A sign across exit do and installing an all staff if the door is of the staff if the staf	ed no one is usually at the ys but due to an event some that day. The church staff-A time R1 had shown up and who was with R1 was on. The church staff-A on] took R1 with him to the that a parishioner called the y took R1 to Walgreens to get isting. The church staff-A then her returned R1 to the facility. Stated there were a couple of ea that the staff alerted them elity reports R1 missing they be bringing him back.  You on 6/10/21 at 3:00 pm., the ere currently in the process of pleting elopement residents with wander guards and by 6/11/21. In the process idents with wander guards on pors screened to see if they and know what year it is to pad and get out into the a was to reach out to Advanced new wander guard system as the current company is also stated the other der guards had not attempted at allow the same alarm on the allow the same alarm on the	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
00055				C <b>06/11/2021</b>		
				06/1	1/2021	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  4247 MEST PROADMAY						
INE EXTENDED HEA	ITHCARE	_	AI			
(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE	
Continued From pa	ge 13	2 830				
was removed on 6/ secured unalarmed documentation and residents, elopeme dementia, but the nathelower scope and which indicated no more than minimal jeopardy because the elopement risk and exhibited signs of each of wander guards.	11/21, when the facility doors, supplied educated all staff on missing nt, wander guard alarms and oncompliance remained at d severity level of D - isolated, actual harm with potential for harm that is not immediate he facility failed to identity an reassess residents who dopement and continued use					
3/26/08 and review wander guard is a sif a resident leaves wander guard alarm. The procedure incluenvironment for resident and ensure that the maintain safety with through identifying upon admission, quisignificant change i applying wander guexhibit exit seeking ability to leave the fimplemented including residents the residents currenand analysis of haz makes attempts to statements they waindividualized residents	ed 6/10/21 included the use of safe alternative that alerts staff a unit or the facility where a n system is in place.  uded: provide a safe sidents who are exit seeking by are in secure location to nout leaving the facility residents at risk of elopement learterly, annually and with n condition and through leard bracelet for residents that tendencies and that have the facility; processes the identification of hazards risk of potentially eloping in the environment, evaluation leards and risks if resident elope or makes verbal and to leave, implementation of ent centered interventions					
	ROVIDER OR SUPPLIER  SUMMARY STA  (EACH DEFICIENCY REGULATORY OR LE  Continued From pa  The immediate jeon was removed on 6/ secured unalarmed documentation and residents, elopeme dementia, but the number of the lower scope and which indicated no more than minimal jeopardy because the lopement risk and exhibited signs of elopement risk and exhibited signs of elopement risk and exhibited signs of elopement guards.  Facility policy Poter 3/26/08 and review wander guard is a siff a resident leaves wander guard alarm. The procedure incluenvironment for residents residents that the maintain safety with through identifying upon admission, qualificant change is applying wander guexhibit exit seeking ability to leave the fimplemented including residents the residents current and analysis of haz makes attempts to statements they was individualized residents and analysis of haz makes adequate significant change is applying wander guexhibit exit seeking ability to leave the fimplemented including residents the residents current and analysis of haz makes attempts to statements they was individualized residents and analysis of haz makes adequate significant change is applying wander guexhibit exit seeking ability to leave the fimplemented including residents the residents current and analysis of haz makes attempts to statements they was individualized residents and analysis of haz makes adequate significant change is applying wander guexhibit exit seeking ability to leave the fimplemented including residents the residents current and analysis of haz makes attempts to statements they was individualized residents.	O0955  ROVIDER OR SUPPLIER  STREET ADD  1347 WES WINONA,  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 13  The immediate jeopardy that began on 6/5/21, was removed on 6/11/21, when the facility secured unalarmed doors, supplied documentation and educated all staff on missing residents, elopement, wander guard alarms and dementia, but the noncompliance remained at the lower scope and severity level of D - isolated, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy because the facility failed to identity an elopement risk and reassess residents who exhibited signs of elopement and continued use	ROVIDER OR SUPPLIER  STREET ADDRESS, CITY, S  INE EXTENDED HEALTHCARE  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  The immediate jeopardy that began on 6/5/21, was removed on 6/11/21, when the facility secured unalarmed doors, supplied documentation and educated all staff on missing residents, elopement, wander guard alarms and dementia, but the noncompliance remained at the lower scope and severity level of D - isolated, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy because the facility failed to identity an elopement risk and reassess residents who exhibited signs of elopement and continued use of wander guards.  Facility policy Potential for Elopement dated 3/26/08 and reviewed 6/10/21 included the use of wander guard is a safe alternative that alerts staff if a resident leaves a unit or the facility where a wander guard alarm system is in place. The procedure included: provide a safe environment for residents who are exit seeking and ensure that they are in secure location to maintain safety without leaving the facility through identifying residents at risk of elopement upon admission, quarterly, annually and with significant change in condition and through applying wander guard bracelet for residents that exhibit exit seeking tendencies and that have the ability to leave the facility; processes implemented include identification of hazards including residents risk of potentially eloping in the residents current environment, evaluation and analysis of hazards and risks if resident makes attempts to elope or makes verbal statements they want to leave, implementation of individualized resident centered interventions such as adequate supervision and monitoring for	ROVIDER OR SUPPLIER  ROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1347 WEST BROADWAY WINONA, MN 55987  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 13  The immediate jeopardy that began on 6/5/21, was removed on 6/11/21, when the facility secured unalarmed doors, supplied documentation and educated all staff on missing residents, elopement, wander guard alarms and dementia, but the noncompliance remained at the lower scope and severity level of D - isolated, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy because the facility falled to identity an elopement risk and reassess residents who exhibited signs of elopement and continued use of wander guard is a safe alternative that alerts staff if a resident leaves a unit or the facility where a wander guard alarm system is in place. 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WINCH  B. WOUDERS  B. WING  B. WINCH  B. W	

Minnesota Department of Health STATE FORM

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3  A. BUILDING:		X3) DATE SURVEY COMPLETED		
		00955	B. WING			C <b>11/2021</b>	
NAME OF I	PROVIDER OR SUPPLIER		T ADDRESS, CITY, S	STATE, ZIP CODE	1 00.		
SAINT ANNE EXTENDED HEALTHCARE 1347 WEST BROADWAY							
WINONA,			NA, MN 55987	T			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 830	for effectiveness of tracking related to a testing the wander alarms will only soumain entrance, and resident on a floor of wander guard furth implemented to assist the unit or all attem resident to the security of nursing (review applicable president' elopementers and to ensure the compresident to ensure ong quality assurance.	interventions, behavior attempts to leave building, guard each shift, notification and on 5th and 2nd floor, the ground floor entrance, if a other than 5th or 2nd has a er supervision will need to be sure resident does not leave upts will be made to move the ure unit if room is available.  THOD OF CORRECTION: To (DON), or designee, could solicies and procedures for ts; then revise as needed to thensive assessment and carents; then educate staff and poing compliance and reports.  R CORRECTION: Twenty-or	ee De D				

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