DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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.

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

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

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.

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)

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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

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 _____	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**

(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 On 6/10/21 and 6/11/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5233034C (MN73567), with a deficiency cited at F689. The survey resulted in an Immediate Jeopardy (IJ)when the facility failed to assess and implement interventions to prevent elopement for 1 of 3 residents (R)1 reviewed for elopement. The IJ began on 6/5/21 at 8:41 a.m., when R1 exited the unsecured door, exited the door on the main floor to the outdoors and walked around the facility unattended by staff. The facility administrator and director of nursing (DON) were notified of the IJ on 6/11/21 at 9:19 a.m. The IJ was removed on 6/11/21 at 4:37 p.m. when the facility implemented interventions to prevent reoccurrence. The above findings constituted substandard quality of care, and an extended survey was conducted on 6/11/21. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

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

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SAINT ANNE EXTENDED HEALTHCARE	**1347 WEST BROADWAY WINONA, MN 55987**

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify an increased risk of elopement for 1 of 3 (R1) residents equipped with security safety alarm devices (aka. wander guard) who exited the building through unalarmed exit doors. The facility's failure resulted in an Immediate Jeopardy (IJ) when R1 exited the building unnoticed through unsecured doors. This practice had the potential to affect other residents who had wander guard system devices in place at the time of survey for 2 of 2 residents (R3 and R4). The IJ began on 6/5/21, at 08:41 a.m. when R1 exited the 4th floor and into a stairwell through an unsecured exit door to the main floor and walked around the building outdoors to a nearby church with out being noticed. The facility administrator and director of nursing (DON) were notified of the IJ on 6/11/21, at 09:19 a.m. The IJ was removed	F 689	Facility has systems in place to ensure residents are free of accident hazards, are supervised and elopement devices are working properly. (R1) was transferred to the secured memory care unit on 6/5/21 and had safety checks implemented immediately. (R3 & R4) elopement risk assessments were completed by 6/11/21. Facility policies related to Missing Resident, Potential for Elopement, and Wanderguard placement procedures were reviewed with licensed nursing staff and included education on checking the functionality of the wanderguard bracelets. All maintenance staff were educated on the functionality of the wanderguard sensor equipment. All	7/12/21

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F 689	Continued From page 2 on 6/11/21, at 4:37 p.m. but noncompliance remained at the lower scope and severity level of D - isolated, scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. 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. R1's care plan dated 3/30/21, included: at risk for elopement as evident by history of attempts to leave facility unattended, wander aimlessly, impaired safety awareness and disoriented to place with interventions to check wander guard placement right wrist and function every shift, document incidents of wandering, encourage activities, structured daily routine, distract from wandering by offering diversions, and provide safe place to wander. R1's facility reported incident to State agency dated 6/5/21 at 10:11 a.m. indicated facility received call from receptionist stating that R1 was said to be found at [name] church and wander guard in place was working before time of incident. R1's progress note dated 6/5/21, at 10:38 a.m. included, writer received a call from receptionist stating that they got a call from the [Name]	F 689	nursing staff were reeducated on reporting any malfunctioning equipment to the nurse, ED, DON. All education was completed as noted in the abatement plan. All Elopement risk assessments will be completed/reviewed upon admission, quarterly, annually and with any significant change in cognitive status. Any wanderguard bracelets placed, at this time five, will be checked for placement and functionality each shift via the electronic Treatment Administration Record. As outlined in the 2567, ED-A placed a stop sign across exit door on main floor in stairwell and installed an alarm system that alerts staff if the door is opened at any time. The alarm was not on the door at the time of the elopement. DON or their designee will perform weekly audits to assure elopement risk assessments are completed as outlined above. Environmental Services Director or their designee will review audits of elopement equipment on a weekly basis to ensure compliance. Results of audit findings will be discussed at IDT meetings and at the facility Quality Council meeting. Ongoing frequency and duration to be determined through analysis and review of results.	

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F 689	Continued From page 3 Church stating R1 was found to be over there and they took R1 to the lake and also got him a new shaver from Walgreens; R1 returned to Saint Anne's Extended Healthcare on to 4th floor at 9:45 a.m.; R1 did not have any injuries and stated he was going to go and get himself a new shaver; writer educated R1 on the importance of safety and how he shouldn't leave the building alone; wander guard is working and he set the alarms off on the main entrance and 5th floor elevators; for an intervention resident was moved up to 5th floor for his safety; resident was okay with the move and understood the reasoning behind it; writer contacted his emergency contact and updated him about the move and the incident and emergency contact thanked writer for the update; DON was updated and made aware of the situation and had made the decision to transfer resident to 5th floor for safety reasons. During observation and interview on 6/10/21, at 9:15 a.m. R1's room prior to the elopement was directly across from the 4th floor stairwell. There was a piece of paper on the door that read [the code to exit]. DON stated on the main floor the inside sliding door and lower floor where staff enter were locked and have had wander guard alarms in place. DON stated the main entrance sliding doors that exits to outside does not include the wander guard alarm. DON indicated they believed R1 went down four flights of stairs and walked out the main door that did not have an alarm unnoticed. DON stated R1 wander guard was implemented 3/23/21 after observing R1 wandering the halls. Review of R1's Progress notes from 3/19/21 to 6/4/21 revealed the following:	F 689	Director of Nursing or their designee are responsible for monitoring of this plan of correction. Completion Date: 7/12/21	

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F 689	Continued From page 4	F 689		

-3/19/2021, at 9:43 p.m. R1 had been up and down the halls several times transferring himself; staff assisted him and sat 1:1 with him; R1 then packed his bag and insisted he was leaving and put on his coat but was then agreeable to sit down and eat a snack first; writer called his friend to let him talk to him but unfortunately this did not calm R1; staff ambulated up and down hall again with R1 and then stated he wanted to watch TV.

-3/23/2021, at 2:30 a.m. R1 was observed walking around the corner from the North stairwell door and stated he heard someone at the door and needed to check; and door alarm was not sounding and it appeared he did not attempt to open the door.

-3/23/2021, at 8:09 p.m. wander guard was placed on R1 right wrist to alert staff if he were to exit the building; R1 has wandered down the hall towards exit doors as well as speaking of getting on the elevator and going shopping; wander guard will be checked each shift for performance and functionality and documented in the treatment administration record.

R1's record lacked an updated elopement risk assessment being completed after attempts, verbal comments of wanting to leave or the placement of the wander guard.

-3/24/2021, at 1:53 p.m. R1 came to elevator and hit button; Housekeeping staff noted him attempting to open door on stairwell unsuccessfully then went towards elevator; R1 stated he was going to go home and get his shaver; redirected out to solarium to monitor; R1

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F 689	Continued From page 5 returned to room and remained to have everything packed up and ready to go. -3/27/2021, 3:33 p.m., included an observation of R1 getting onto the elevator with his coat on and bags packed; writer quickly intervened. R1 became very upset with writer and stormed out of the elevator towards stairwell. and noted the stop sign so turned around and stormed past elevator, pushed divider roughly out of the way and turned around returning to elevator; R1 angry with staff stating we were "keeping him against his will" ... -3/29/2021, at 8:57 p.m. reception called and R1 had taken elevator down to first floor then went down to ground floor but was brought back to 4th floor by staff; R1 was initially resistive to returning to unit but was eventually cooperative; R1 had packed suitcase and had brought this with him; R1 was later noticed standing by elevator with suitcase; R1 stated he wanted to leave but he was redirected back to his room. -6/03/2021, at 2:06 p.m. the social worker was on 1st floor for another matter and observed R1 arrive with restorative staff from the elevator; restorative staff stated she found R1 on the 2nd floor and had stated he was going to the chapel; restorative staff rode elevator to 1st floor with R1; no church service and R1 stated he wanted to go outside for a walk; social worker walked with R1 and receptionist contacted 4th floor staff to come get R1. -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.	F 689		

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 _____	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**

(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 689	Continued From page 6	F 689		

-6/04/2021, at 4:55 p.m. R1 became more agitated and had his bag packed and was trying to get on elevator to get to his car; 3 staff assisted to redirect; R1 then moved towards the staircase in which he was not able to put code for door to open; R1 then told staff he would return to his room and call someone to help and shortly after the nurse received a call from receptionist stating R1 had called 911 asking for help and they wanted to make sure everything was ok.

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 on 6/10/21 at 10:17 a.m., DON stated there had not been other incidents of elopement from facility for other residents. DON stated elopement assessment should be completed upon admission, quarterly, and yearly. DON stated the team discusses behavior concerns daily including if wandering or elopement for residents.

During an interview on 6/10/21 at 10:33 a.m., registered nurse (RN)-B stated R1 had made statements of wanting to go to church which was on the main floor. RN-B stated the wander guard was implemented due to the statements and staff were to escort R1 off floor using elevator to attend church or other activities. RN-B stated there was not a wander guard alarm system at elevator on 4th floor and only one at main entrance and lower floor entrance.

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F 689	Continued From page 7	F 689		

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 no alarms had sounded but did sound when R1 returned into building. RN-C stated he notified the DON and emergency contact. RN-C stated R1 likely took the elevator down to main level when he left the building. RN-C stated the elevators on 4th floor do not have wander guard

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	245233	A. BUILDING _____ B. WING _____	C 06/11/2021

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SAINT ANNE EXTENDED HEALTHCARE	**1347 WEST BROADWAY WINONA, MN 55987**

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F 689	Continued From page 8	F 689		

alarms. RN-C stated R1 was independent and had not been exit seeking and was easily directed. RN-C stated there had not been any other incidents of elopement for R1 or others. RN-C stated R1 was moved to secure unit on 5th floor upon return to facility.

During an interview on 6/10/21, at 12:20 p.m., Social worker (SW)-A stated an elopement risk assessment was completed upon admission for R1 on 3/17/21 and had not had another elopement risk assessment completed since that time. SW-A stated R1 would pack his bags and sit in the solarium and began to wander more so the facility implemented a wander guard band for R1. SW-A stated on 6/3/21, she saw R1 exit off elevator with a restorative staff and R1 had indicated he wanted to go to church but at that time there was no church services. SW-A stated R1 then wanted to go outside so she took him outside and had the receptionist call for staff to come and take him back to 4th floor. SW-A stated the restorative aide had stated she found R1 on the 2nd floor and brought him down to the 1st floor. SW-A stated his wander guard did alarm when taking R1 through main doors to outside. SW-A stated there was discussion with therapeutic recreation to increase time with residents in general, but no additional interventions implemented at that time. SW-A stated all doors to stairwells had codes to enter and there was a wander guard alarm system on the main floor doors and lower-level back entrance. SW-A stated 2nd and 5th floor have wander guard alarm systems at the elevator but not on 3rd or 4th floor. SW-A stated R1 was moved to the secure unit on 5th floor and remains there on 30-minute checks. SW-A

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SAINT ANNE EXTENDED HEALTHCARE	1347 WEST BROADWAY WINONA, MN 55987

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F 689	Continued From page 9	F 689		

stated no one really knew how R1 left the 4th floor, whether it was the stairwell or the elevator, but assumed he took the elevator. SW-A stated the facility cameras showed R1 exiting building at 8:41 a.m. though RN-C stated R1 was last seen on floor around 9:00 a.m. SW-A stated they had not been able to discuss the incident with the person who found R1. SW-A stated the person notified the facility 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 9:45 a.m. SW-A further stated R4 was moved to 4th floor from 5th floor, due to an incident not relating to elopement, but continued to have the wander guard in place and had not attempted to leave the unit. SW-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 had not been assessed to determine if R1 knew the current year or if R1 would be able to enter the code to the exit door to the stairwell on the 4th floor. DON stated R1 had exited 4th floor using elevator before but had never attempted to leave the facility. DON stated she thought the residents who required the wander guard placement had been reassessed and should have been. DON stated the social worker completed the elopement assessments and stated any new admissions with elopement risk would ideally be admitted to the secure unit on 5th floor. The administrator stated she reviewed

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	245233	A. BUILDING _____ B. WING _____	C 06/11/2021

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F 689	Continued From page 10	F 689		

the facility cameras and R1 exit the building through the stairwell exit then out of building at 8:41 a.m. and was last seen on camera on east side of building at 8:44 a.m. The administrator stated the elevator camera on main floor did not show R1 exiting the elevator at any time prior to the exit in the stairwell leaving them to believe R1 had taken the stairs from 4th floor or took elevator to bottom floor and entered stairwell from bottom floor and climbed the stairs to the exit door at main level in the stairwell. The administrator stated the camera times were accurate. DON stated the stairwell on main floor and bottom floor was used by staff. DON stated she was alerted by staff at 9:23 a.m. of the notification that R1 was found at the church next door. The administrator stated the third and fourth floors do not have wander guard alarms yet and verified the facility had one resident on each floor who required the use of the wander guard.

During an interview on 6/10/21 at 2:33 p.m., environmental director (ED)-A stated he felt the current wander guard alarm system was obsolete and the facility had checked into a new system in the past to add alarms in other areas of the building. ED-A stated he had not recently requested quotes from other companies for updating the system. ED-A confirmed the stairwell exit on main floor was not alarmed currently and could be accessed from main floor or bottom floor without code. ED-A stated on main floor from the vestibule entering the stairwell the doors are locked but if your coming from inside the stairwell into the vestibule to exit to the outside, the door in not locked or alarmed.

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	245233	A. BUILDING _____ B. WING _____	C 06/11/2021

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F 689	Continued From page 11	F 689		

During an interview on 6/10/21 at 2:43 p.m., the church staff-A stated no one is usually at the church on Saturdays but due to an event some staff were present that day. The church staff-A could not verify the time R1 had shown up and stated the [person] who was with R1 was currently on vacation. The church staff-A indicated the [person] took R1 with him to the event location and that a parishioner called the facility to notify they took R1 to Walgreens to get a razor R1 was insisting. The church staff-A then stated the parishioner returned R1 to the facility. The church staff-A stated there were a couple of police officers in area that the staff alerted them indicating if the facility reports R1 missing they have him and will be bringing him back.

During an interview on 6/10/21 at 3:00 pm., the DON stated they were currently in the process of reviewing and completing elopement assessments of all residents with wander guards and would be finished by 6/11/21. In the process of having those residents with wander guards on 2nd, 3rd and 4th floors screened to see if they can read the sign and know what year it is to enter it into the keypad and get out into the stairwells. Our plan was to reach out to Advanced Wireless and get a new wander guard system with that company as the current company is obsolete. The DON also stated the other residents with wander guards had not attempted to leave the facility.

During an observation and interview on 6/11/21 at 2:35 p.m., ED-A was observed placing a stop sign across exit door on main floor in stairwell and installing an alarm system that would alert staff if the door is opened any time. ED-A stated

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F 689	Continued From page 12	F 689		

he will also be installing the same alarm on the east exit door from building.

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

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F 689	Continued From page 13 individualized resident centered interventions such as adequate supervision and monitoring for triggers related to attempting to elope, monitoring for effectiveness of interventions, behavior tracking related to attempts to leave building, testing the wander guard each shift, notification alarms will only sound on 5th and 2nd floor, the main entrance, and ground floor entrance, if a resident on a floor other than 5th or 2nd has a wander guard further supervision will need to be implemented to assure resident does not leave the unit or all attempts will be made to move the resident to the secure unit if room is available.	F 689		

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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

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

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

Please 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00955	A. BUILDING: _____ B. WING _____	C 06/11/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/10/21 and 6/11/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will	2 000		

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2 000	Continued From page 1 be completed. The following complaint was found to be SUBSTANTIATED: H5233034C (MN73567), with a licensing order issued at 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify an increased risk of elopement for 1 of 3 (R1) residents equipped with security safety alarm devices (aka. wander guard) who exited the building through unalarmed exit doors. The facility's failure resulted in an Immediate Jeopardy (IJ) when R1 exited the building unnoticed through unsecured doors. This practice had the potential to affect other residents who had wander guard system devices in place at the time of survey for 2 of 2 residents (R3 and R4).	2 830	corrected	7/12/21

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	00955	A. BUILDING: _____ B. WING _____	C 06/11/2021

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2 830	Continued From page 3 The IJ began on 6/5/21, at 08:41 a.m. when R1 exited the 4th floor and into a stairwell through an unsecured exit door to the main floor and walked around the building outdoors to a nearby church with out being noticed. The facility administrator and director of nursing (DON) were notified of the IJ on 6/11/21, at 09:19 a.m. The IJ was removed on 6/11/21, at 4:37 p.m. but noncompliance remained at the lower scope and severity level of D - isolated, scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. 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. R1's care plan dated 3/30/21, included: at risk for elopement as evident by history of attempts to leave facility unattended, wander aimlessly, impaired safety awareness and disoriented to place with interventions to check wander guard placement right wrist and function every shift, document incidents of wandering, encourage activities, structured daily routine, distract from wandering by offering diversions, and provide safe place to wander. R1's facility reported incident to State agency dated 6/5/21 at 10:11 a.m. indicated facility received call from receptionist stating that R1	2 830		

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2 830	Continued From page 4 was said to be found at [name] church and wander guard in place was working before time of incident. R1's progress note dated 6/5/21, at 10:38 a.m. included, writer received a call from receptionist stating that they got a call from the [Name] Church stating R1 was found to be over there and they took R1 to the lake and also got him a new shaver from Walgreens; R1 returned to Saint Anne's Extended Healthcare on to 4th floor at 9:45 a.m.; R1 did not have any injuries and stated he was going to go and get himself a new shaver; writer educated R1 on the importance of safety and how he shouldn't leave the building alone; wander guard is working and he set the alarms off on the main entrance and 5th floor elevators; for an intervention resident was moved up to 5th floor for his safety; resident was okay with the move and understood the reasoning behind it; writer contacted his emergency contact and updated him about the move and the incident and emergency contact thanked writer for the update; DON was updated and made aware of the situation and had made the decision to transfer resident to 5th floor for safety reasons. During observation and interview on 6/10/21, at 9:15 a.m. R1's room prior to the elopement was directly across from the 4th floor stairwell. There was a piece of paper on the door that read [the code to exit]. DON stated on the main floor the inside sliding door and lower floor where staff enter were locked and have had wander guard alarms in place. DON stated the main entrance sliding doors that exits to outside does not include the wander guard alarm. DON indicated they believed R1 went down four flights of stairs and walked out the main door that did not have	2 830		

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2 830	Continued From page 5 an alarm unnoticed. DON stated R1 wander guard was implemented 3/23/21 after observing R1 wandering the halls. Review of R1's Progress notes from 3/19/21 to 6/4/21 revealed the following: -3/19/2021, at 9:43 p.m. R1 had been up and down the halls several times transferring himself; staff assisted him and sat 1:1 with him; R1 then packed his bag and insisted he was leaving and put on his coat but was then agreeable to sit down and eat a snack first; writer called his friend to let him talk to him but unfortunately this did not calm R1; staff ambulated up and down hall again with R1 and then stated he wanted to watch TV. -3/23/2021, at 2:30 a.m. R1 was observed walking around the corner from the North stairwell door and stated he heard someone at the door and needed to check; and door alarm was not sounding and it appeared he did not attempt to open the door. -3/23/2021, at 8:09 p.m. wander guard was placed on R1 right wrist to alert staff if he were to exit the building; R1 has wandered down the hall towards exit doors as well as speaking of getting on the elevator and going shopping; wander guard will be checked each shift for performance and functionality and documented in the treatment administration record. R1's record lacked an updated elopement risk assessment being completed after attempts, verbal comments of wanting to leave or the placement of the wander guard. -3/24/2021, at 1:53 p.m. R1 came to elevator and	2 830		

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2 830	Continued From page 6 hit button; Housekeeping staff noted him attempting to open door on stairwell unsuccessfully then went towards elevator; R1 stated he was going to go home and get his shaver; redirected out to solarium to monitor; R1 returned to room and remained to have everything packed up and ready to go. -3/27/2021, 3:33 p.m., included an observation of R1 getting onto the elevator with his coat on and bags packed; writer quickly intervened. R1 became very upset with writer and stormed out of the elevator towards stairwell. and noted the stop sign so turned around and stormed past elevator, pushed divider roughly out of the way and turned around returning to elevator; R1 angry with staff stating we were "keeping him against his will" ... -3/29/2021, at 8:57 p.m. reception called and R1 had taken elevator down to first floor then went down to ground floor but was brought back to 4th floor by staff; R1 was initially resistive to returning to unit but was eventually cooperative; R1 had packed suitcase and had brought this with him; R1 was later noticed standing by elevator with suitcase; R1 stated he wanted to leave but he was redirected back to his room. -6/03/2021, at 2:06 p.m. the social worker was on 1st floor for another matter and observed R1 arrive with restorative staff from the elevator; restorative staff stated she found R1 on the 2nd floor and had stated he was going to the chapel; restorative staff rode elevator to 1st floor with R1; no church service and R1 stated he wanted to go outside for a walk; social worker walked with R1 and receptionist contacted 4th floor staff to come get R1.	2 830		

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2 830	Continued From page 7 -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 p.m. R1 became more agitated and had his bag packed and was trying to get on elevator to get to his car; 3 staff assisted to redirect; R1 then moved towards the staircase in which he was not able to put code for door to open; R1 then told staff he would return to his room and call someone to help and shortly after the nurse received a call from receptionist stating R1 had called 911 asking for help and they wanted to make sure everything was ok. 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 on 6/10/21 at 10:17 a.m., DON stated there had not been other incidents of elopement from facility for other residents. DON stated elopement assessment should be completed upon admission, quarterly, and yearly. DON stated the team discusses behavior concerns daily including if wandering or elopement for residents. During an interview on 6/10/21 at 10:33 a.m., registered nurse (RN)-B stated R1 had made statements of wanting to go to church which was on the main floor. RN-B stated the wander guard was implemented due to the statements and staff were to escort R1 off floor using elevator to attend church or other activities. RN-B stated there was not a wander guard alarm system at	2 830		

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2 830	Continued From page 8 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 no alarms had sounded but did sound when R1 returned into building. RN-C stated he notified the DON and emergency contact. RN-C stated R1 likely took the elevator down to main	2 830		

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2 830	Continued From page 9 level when he left the building. RN-C stated the elevators on 4th floor do not have wander guard alarms. RN-C stated R1 was independent and had not been exit seeking and was easily directed. RN-C stated there had not been any other incidents of elopement for R1 or others. RN-C stated R1 was moved to secure unit on 5th floor upon return to facility. During an interview on 6/10/21, at 12:20 p.m., Social worker (SW)-A stated an elopement risk assessment was completed upon admission for R1 on 3/17/21 and had not had another elopement risk assessment completed since that time. SW-A stated R1 would pack his bags and sit in the solarium and began to wander more so the facility implemented a wander guard band for R1. SW-A stated on 6/3/21, she saw R1 exit off elevator with a restorative staff and R1 had indicated he wanted to go to church but at that time there was no church services. SW-A stated R1 then wanted to go outside so she took him outside and had the receptionist call for staff to come and take him back to 4th floor. SW-A stated the restorative aide had stated she found R1 on the 2nd floor and brought him down to the 1st floor. SW-A stated his wander guard did alarm when taking R1 through main doors to outside. SW-A stated there was discussion with therapeutic recreation to increase time with residents in general, but no additional interventions implemented at that time. SW-A stated all doors to stairwells had codes to enter and there was a wander guard alarm system on the main floor doors and lower-level back entrance. SW-A stated 2nd and 5th floor have wander guard alarm systems at the elevator but not on 3rd or 4th floor. SW-A stated R1 was moved to the secure unit on 5th floor and	2 830		

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2 830	Continued From page 10 remains there on 30-minute checks. SW-A stated no one really knew how R1 left the 4th floor, whether it was the stairwell or the elevator, but assumed he took the elevator. SW-A stated the facility cameras showed R1 exiting building at 8:41 a.m. though RN-C stated R1 was last seen on floor around 9:00 a.m. SW-A stated they had not been able to discuss the incident with the person who found R1. SW-A stated the person notified the facility 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 9:45 a.m. SW-A further stated R4 was moved to 4th floor from 5th floor, due to an incident not relating to elopement, but continued to have the wander guard in place and had not attempted to leave the unit. SW-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 had not been assessed to determine if R1 knew the current year or if R1 would be able to enter the code to the exit door to the stairwell on the 4th floor. DON stated R1 had exited 4th floor using elevator before but had never attempted to leave the facility. DON stated she thought the residents who required the wander guard placement had been reassessed and should have been. DON stated the social worker completed the elopement assessments and stated any new admissions with elopement risk would ideally be admitted to the secure unit on 5th floor. The administrator stated she reviewed	2 830		

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2 830	Continued From page 11 the facility cameras and R1 exit the building through the stairwell exit then out of building at 8:41 a.m. and was last seen on camera on east side of building at 8:44 a.m. The administrator stated the elevator camera on main floor did not show R1 exiting the elevator at any time prior to the exit in the stairwell leaving them to believe R1 had taken the stairs from 4th floor or took elevator to bottom floor and entered stairwell from bottom floor and climbed the stairs to the exit door at main level in the stairwell. The administrator stated the camera times were accurate. DON stated the stairwell on main floor and bottom floor was used by staff. DON stated she was alerted by staff at 9:23 a.m. of the notification that R1 was found at the church next door. The administrator stated the third and fourth floors do not have wander guard alarms yet and verified the facility had one resident on each floor who required the use of the wander guard. During an interview on 6/10/21 at 2:33 p.m., environmental director (ED)-A stated he felt the current wander guard alarm system was obsolete and the facility had checked into a new system in the past to add alarms in other areas of the building. ED-A stated he had not recently requested quotes from other companies for updating the system. ED-A confirmed the stairwell exit on main floor was not alarmed currently and could be accessed from main floor or bottom floor without code. ED-A stated on main floor from the vestibule entering the stairwell the doors are locked but if your coming from inside the stairwell into the vestibule to exit to the outside, the door in not locked or alarmed. During an interview on 6/10/21 at 2:43 p.m., the	2 830		

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2 830	Continued From page 12 church staff-A stated no one is usually at the church on Saturdays but due to an event some staff were present that day. The church staff-A could not verify the time R1 had shown up and stated the [person] who was with R1 was currently on vacation. The church staff-A indicated the [person] took R1 with him to the event location and that a parishioner called the facility to notify they took R1 to Walgreens to get a razor R1 was insisting. The church staff-A then stated the parishioner returned R1 to the facility. The church staff-A stated there were a couple of police officers in area that the staff alerted them indicating if the facility reports R1 missing they have him and will be bringing him back. During an interview on 6/10/21 at 3:00 pm., the DON stated they were currently in the process of reviewing and completing elopement assessments of all residents with wander guards and would be finished by 6/11/21. In the process of having those residents with wander guards on 2nd, 3rd and 4th floors screened to see if they can read the sign and know what year it is to enter it into the keypad and get out into the stairwells. Our plan was to reach out to Advanced Wireless and get a new wander guard system with that company as the current company is obsolete. The DON also stated the other residents with wander guards had not attempted to leave the facility. During an observation and interview on 6/11/21 at 2:35 p.m., ED-A was observed placing a stop sign across exit door on main floor in stairwell and installing an alarm system that would alert staff if the door is opened any time. ED-A stated he will also be installing the same alarm on the east exit door from building.	2 830		

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2 830	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 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 triggers related to attempting to elope, monitoring	2 830		

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2 830	Continued From page 14 for effectiveness of interventions, behavior tracking related to attempts to leave building, testing the wander guard each shift, notification alarms will only sound on 5th and 2nd floor, the main entrance, and ground floor entrance, if a resident on a floor other than 5th or 2nd has a wander guard further supervision will need to be implemented to assure resident does not leave the unit or all attempts will be made to move the resident to the secure unit if room is available. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures for resident' elopements; then revise as needed to ensure the comprehensive assessment and care planning of such events; then educate staff and audit to ensure ongoing compliance and report to quality assurance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		