



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 12, 2023

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

RE: CCN: 245233
Cycle Start Date: April 18, 2023

Dear Administrator:

On May 8, 2023, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink that reads 'Lori Hagen'.

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

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May 12, 2023
Administrator
Saint Anne Extended Healthcare
1347 West Broadway Street
Winona, MN 55987

Re: Reinspection Results
Event ID: DDW412

Dear Administrator:

On May 8, 2023, 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 April 18, 2023. At this time these correction orders were found corrected.

Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink that reads 'Lori Hagen'.

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us



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April 21, 2023

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

RE: CCN: 245233
Cycle Start Date: April 18, 2023

Dear Administrator:

On April 18, 2023, a survey was completed at your facility by the Minnesota Department of Health, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) , as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 18, 2023, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 18, 2023, (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

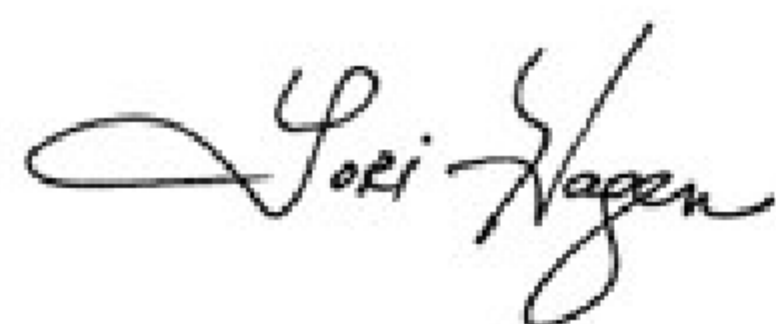
Saint Anne Extended Healthcare

April 21, 2023

Page 4

Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink that reads "Lori Hagen". The signature is written in a cursive style with a large, stylized initial "L" and "H".

Lori Hagen, Compliance Analyst

Federal Enforcement

Health Regulation Division

Minnesota Department of Health

Telephone: 651-201-4306

E-Mail: Lori.Hagen@state.mn.us

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

PRINTED: 04/25/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245233	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/18/2023
NAME OF PROVIDER OR SUPPLIER SAINT ANNE EXTENDED HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1347 WEST BROADWAY STREET WINONA, MN 55987		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 4/17/23 and 4/18/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiency issued. H50391343C (MN00092042), H52331342C (MN00089854), H52331047C (MN00092481), H52331031C (MN00092435) The following complaint was reviewed. H52331082C (MN00092439) with a deficiency issued at F656 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656			4/28/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/25/2023

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

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F 656	Continued From page 1 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 656			

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F 656	Continued From page 2 Based on interview and document review the facility failed to follow the individualized care plan for choices for 2 of 3 (R4, R7) residents reviewed for abuse. Findings include: R4's Face Sheet, indicated R4 was admitted to the facility with diagnoses of dementia without behavioral disturbance, anxiety, unspecified condition associated with female genital organs and menstrual cycle. R4's quarterly Minimum Data Set (MDS) dated 3/28/23, indicated R4 was cognitively intact, needed assist of one with dressing, toilet use, and personal hygiene. R4's care plan dated 11/29/18 identified R4 preferred no male care givers dated 10/26/22. R4's licensed staff care sheet (abbreviated care plan for licensed staff) updated 3/24/23, identified R4 as assist of 1 with transfers, encourage ambulation. Stay with her in the bathroom. R4's care sheet did not include R4's preference of no male care givers as directed in the care plan. R4's nursing assistant care sheet (abbreviated care plan used by direct care staff) dated 4/4/23, identified R4 as assist of one staff with gait belt and walker for transfers, assist of one staff to dress and groom. Further included R4 will not ask for help and does not want to be a bother-anticipate and offer. R4's care sheet did not include R4's preference of no male care givers as directed in the care plan. During an interview on 4/17/23, at 12:53 p.m.			F 656	Facility has systems in place to ensure development and implementation of a comprehensive person-centered care plan for each resident. It will include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Facility has reviewed Care Plan Development and Revision policy and Resident Participation in Care Planning policy for accuracy. By 4/20/2023, all residents with gender specific preferences had been interviewed and specific requests have been care planned. Upon admission, if a resident requests a gender specific caregiver, request will be care planned and added to care sheets. Social Services will continue to do trauma informed assessments upon admission and follow up as needed. Behavior expression tracking sheets are being reviewed with behavioral expressions matching care plans and interventions. Re-education for nursing staff occurred via Friday letter on 4/20/2023. Nursing education will be sent out regarding high risk behaviors, new work flow processes, updated Care Plan Development and Revision and Resident Participation in Care Planning policies.		

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F 656	Continued From page 3 nursing assistant (NA)-A indicated he worked the evening shift on 3/31/23, and got R4 ready for bed. NA-A reported he was aware that R4 preferred no male care givers before he had provided the care. NA-A stated he had informed R4 there was not a female NA, however there was were two female nurses that could have assisted. NA-A explained R4 had agreed to the care and he was not aware R4 had been upset about the encounter. During an interview on 4/17/2023, at 11:28 a.m. R4 stated she had a history of having trouble with a male prior to admission to the facility. R4 explained a sign had been put up in her room for her that directed no "male caregivers." R4 was not sure when the sign was put up. R4 explained she was not comfortable with male care givers and the facility had put the sign up for her. When R4 was asked about male aides providing her care, R4 became restless and would not answer direct questions. During an interview on 4/17/23, at 1:16 p.m. nurse manager (NM) for 3rd floor stated she became aware NA-A had provided care to R4 on 4/3/23. NM explained NA-A should have followed the care plan and not provided care to R4. NM stated NA-A should have asked licensed to assist. R7's Face Sheet, indicated R7 was admitted to the facility with diagnoses that included general anxiety disorder. R7's quarterly Minimum Data Set (MDS) dated 3/28/23, indicated R7 was cognitively intact, needed extensive assist of one with dressing,			F 656	Nurse Supervisor will be responsible for implementation of workflow. Daily review of high-risk behaviors will occur and signature sheets will be forwarded to DON for verification. If there is missing information, staff will be addressed one on one and be re-educated. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. The Director of Nursing or their designee is responsible for the monitoring of this plan of correction.		

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F 656	Continued From page 4 toilet use, personal hygiene and was unable to walk. R7's activities of daily living (ADL) care plan dated 7/8/22, identified R7 preferred no male care givers (2/17/23). During an interview on 4/18/23, at 2:30 p.m. R7 stated she has a care plan for female care givers only. R7 stated she has had male care givers attempt to provide cares for her a few times while in the facility. R7 stated the other day a male care givers had attempted to do her cares, however, directed them to go and get female. R7 stated that at times it was hard for her to decipher male staff wanting to provide her with cares or if they were wanting to pursue a relationship with her. R7 stated she already had a wonderful husband and doesn't need a new relationship with a man. During an interview on 4/17/23, at 4:08 p.m. Social Worker (SW) explained upon R4's admission to the facility R4 had told her she only wanted female care givers because she was not comfortable with males. SW stated she was the one that added 'no male care givers' to R4 and R7's care plan. SW explained the care plan did not define "care giver" or which, if any care male staff could provide. SW stated any male providing cares to R4 or R7 would be going against their care plans. During an interview on 4/18/23, at 2:41 p.m. DON stated NA-A should not be providing cares to residents who are care planned to have female only care givers. DON stated NA-A had been provided with coaching to have only females provide cares to those residents. DON was	F 656			

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F 656	Continued From page 5 unable to provide documentation of the education provided. DON stated the care plans were unclear as to what providing cares means or why the residents preferred female care givers. DON stated during an investigation the facility found out R4 had reported trauma about an incident in her past involving male care givers. DON reviewed R4's and R7's care plan related to female care giver preferences. DON stated the care plans needed more information and to be more individualized per resident. A facility policy Care Plan Development and Revision, revised 10/19/16, indicated The resident's care plan is an organized, written guideline for resident care. Written care plans document the resident health needs. Additionally, the written care plan communicates to other nurses and other clinical disciplines the pertinent assessment data, list of problems and identified approaches which are in place to address the problems. The written documentation of a care plan is designed to decrease the risk of incomplete, incorrect, or inaccurate care. It is a mode of interdisciplinary communication to establish care according to best practice: the care plan also provides the tool by which care is evaluated and the point of departure for care changes. The care planning process is multi-disciplinary and is an on-going, evaluative and evolving; the care plan document is updated and reflective of the resident's changing needs. The care plan as a mode of communication enhances continuity of care.	F 656			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 21, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: DDW411

Dear Administrator:

The above facility was surveyed on April 17, 2023, through April 18, 2023, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

Saint Anne Extended Healthcare

April 21, 2023

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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Lori Hagen". The signature is fluid and cursive, with the first name "Lori" and last name "Hagen" clearly distinguishable.

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00955	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/18/2023
NAME OF PROVIDER OR SUPPLIER SAINT ANNE EXTENDED HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1347 WEST BROADWAY STREET WINONA, MN 55987		
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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 4/17/23 and 4/18/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed	2 000			

Minnesota Department of Health

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

Electronically Signed

TITLE

(X6) DATE

04/25/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00955	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/18/2023
NAME OF PROVIDER OR SUPPLIER SAINT ANNE EXTENDED HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1347 WEST BROADWAY STREET WINONA, MN 55987		
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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were reviewed with no deficiency issued. H50391343C (MN00092042), H52331342C (MN00089854), H52331047C (MN00092481), H52331031C (MN00092435) The following complaint was reviewed. H52331082C (MN00092439) with a licensing order issued at 0565. 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the	2 000			

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2 000	Continued From page 2 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. 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	corrected		4/28/23
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to follow the individualized care plan for choices for 2 of 3 (R4, R7) residents reviewed for abuse. Findings include: R4's Face Sheet, indicated R4 was admitted to the facility with diagnoses of dementia without behavioral disturbance, anxiety, unspecified condition associated with female genital organs and menstrual cycle. R4's quarterly Minimum Data Set (MDS) dated	2 565			

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2 565	Continued From page 3 3/28/23, indicated R4 was cognitively intact, needed assist of one with dressing, toilet use, and personal hygiene. R4's care plan dated 11/29/18 identified R4 preferred no male care givers dated 10/26/22. R4's licensed staff care sheet (abbreviated care plan for licensed staff) updated 3/24/23, identified R4 as assist of 1 with transfers, encourage ambulation. Stay with her in the bathroom. R4's care sheet did not include R4's preference of no male care givers as directed in the care plan. R4's nursing assistant care sheet (abbreviated care plan used by direct care staff) dated 4/4/23, identified R4 as assist of one staff with gait belt and walker for transfers, assist of one staff to dress and groom. Further included R4 will not ask for help and does not want to be a bother-anticipate and offer. R4's care sheet did not include R4's preference of no male care givers as directed in the care plan. During an interview on 4/17/23, at 12:53 p.m. nursing assistant (NA)-A indicated he worked the evening shift on 3/31/23, and got R4 ready for bed. NA-A reported he was aware that R4 preferred no male care givers before he had provided the care. NA-A stated he had informed R4 there was not a female NA, however there was were two female nurses that could have assisted. NA-A explained R4 had agreed to the care and he was not aware R4 had been upset about the encounter. During an interview on 4/17/2023, at 11:28 a.m. R4 stated she had a history of having trouble with a male prior to admission to the facility. R4 explained a sign had been put up in her room for	2 565			

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2 565	Continued From page 4 her that directed no "male caregivers." R4 was not sure when the sign was put up. R4 explained she was not comfortable with male care givers and the facility had put the sign up for her. When R4 was asked about male aides providing her care, R4 became restless and would not answer direct questions. During an interview on 4/17/23, at 1:16 p.m. nurse manager (NM) for 3rd floor stated she became aware NA-A had provided care to R4 on 4/3/23. NM explained NA-A should have followed the care plan and not provided care to R4. NM stated NA-A should have asked licensed to assist. R7's Face Sheet, indicated R7 was admitted to the facility with diagnoses that included general anxiety disorder. R7's quarterly Minimum Data Set (MDS) dated 3/28/23, indicated R7 was cognitively intact, needed extensive assist of one with dressing, toilet use, personal hygiene and was unable to walk. R7's activities of daily living (ADL) care plan dated 7/8/22, identified R7 preferred no male care givers (2/17/23). During an interview on 4/18/23, at 2:30 p.m. R7 stated she has a care plan for female care givers only. R7 stated she has had male care givers attempt to provide cares for her a few times while in the facility. R7 stated the other day a male care givers had attempted to do her cares, however, directed them to go and get female. R7 stated that at times it was hard for her to decipher male staff wanting to provide her with cares or if	2 565			

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2 565	Continued From page 5 they were wanting to pursue a relationship with her. R7 stated she already had a wonderful husband and doesn't need a new relationship with a man. During an interview on 4/17/23, at 4:08 p.m. Social Worker (SW) explained upon R4's admission to the facility R4 had told her she only wanted female care givers because she was not comfortable with males. SW stated she was the one that added 'no male care givers' to R4 and R7's care plan. SW explained the care plan did not define "care giver" or which, if any care male staff could provide. SW stated any male providing cares to R4 or R7 would be going against their care plans. During an interview on 4/18/23, at 2:41 p.m. DON stated NA-A should not be providing cares to residents who are care planned to have female only care givers. DON stated NA-A had been provided with coaching to have only females provide cares to those residents. DON was unable to provide documentation of the education provided. DON stated the care plans were unclear as to what providing cares means or why the residents preferred female care givers. DON stated during an investigation the facility found out R4 had reported trauma about an incident in her past involving male care givers. DON reviewed R4's and R7's care plan related to female care giver preferences. DON stated the care plans needed more information and to be more individualized per resident. A facility policy Care Plan Development and Revision, revised 10/19/16, indicated The resident's care plan is an organized, written guideline for resident care. Written care plans document the resident health needs. Additionally,	2 565			

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2 565	Continued From page 6 the written care plan communicates to other nurses and other clinical disciplines the pertinent assessment data, list of problems and identified approaches which are in place to address the problems. The written documentation of a care plan is designed to decrease the risk of incomplete, incorrect, or inaccurate care. It is a mode of interdisciplinary communication to establish care according to best practice: the care plan also provides the tool by which care is evaluated and the point of departure for care changes. The care planning process is multi-disciplinary and is an on-going, evaluative and evolving; the care plan document is updated and reflective of the resident's changing needs. The care plan as a mode of communication enhances continuity of care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565			