DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 18, 2024

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

RE: CCN: 245233
Cycle Start Date: November 4, 2024

Dear Administrator:

On November 4, 2024, 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 actual harm that was not immediate jeopardy (Level G).

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

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(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Civil money penalty, (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

The CMS location may notify you of their determination regarding any imposed remedies.

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

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:

Steven.Delich@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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: **https://forms.web.health.state.mn.us/form/NHDisputeResolution**

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@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 11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE EXTENDED HEALTHCARE	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 10/31/24 and 11/4/24, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed: H52337220C (MN105716) and a deficiency was issued at F689 at PAST NON-COMPLIANCE. Although the provider had implemented corrective action prior to survey, G-level harm was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F 000	Past noncompliance: no plan of correction required.	
F 689 SS=G	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 interview and document review, the facility failed to follow a care planned intervention to prevent or reduce the risk of falls for 1 of 3 residents (R1) reviewed for falls. This resulted in actual harm when R1 fell and sustained a right fibular fracture which required an emergency room (ER) visit. The facility implemented	F 689	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 11/19/2024

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 689	Continued From page 1 immediate corrective action, so the deficient practice was issued at past non-compliance. Findings include: R1's quarterly Minimum Data Set (MDS) dated 8/27/24, identified R1 had severely impaired cognition and diagnoses of dementia, fracture of upper and lower end of right fibula, anxiety disorder and depression. Further identified R1 required 2-person extensive assist with bed mobility, transfers, and toileting. R1 had one fall with injury and two falls with major injury. R1's fall Care Area Assessment (CAA) dated 5/28/24, identified R1's was at risk for falls due to R1 received physician ordered anti-depressant medications. R1 has had one fall during this assessment period. Nursing staff assisted R1 with activities of daily living (ADL)'s as needed according to facility policy. R1 was at risk for fall related injury. No referrals at this time, will proceed to care plan with goal to have no fall related injuries. R1's care plan dated 7/1/24, identified R1 was at risk for falls due to generalized muscle weakness, use of high-risk psychotropic medications, and cognitive impairment. An intervention directed staff will wake and assist R1 to bathroom every day at 11:00 p.m., and 4:00 a.m. Additional intervention dated 8/9/24 identified night light to be used at all times due to R1 keeping the lights off and shades shut most of the time. R1's progress note dated 8/9/24, identified R1 had a fall at 7:15 a.m., R1 was calling out for help and found sitting on the floor in front of her bed. R1's room was dark at the time of the fall with the	F 689		

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F 689	Continued From page 2	F 689		

lights off and the shades pulled down. R1 stated she was on her way back from the bathroom and had attempted to get back into bed when she fell. No injury noted.

R1's Fall Event Report, dated 8/9/24 identified R1 had an unwitnessed fall and was coming back from the bathroom and getting into bed. On 8/9/24 at 10:40 p.m., R1 had no complaints of pain, did have a night light placed in her room in the am and R1 commented she liked it.

R1's progress note dated 8/12/24, identified R1 was heard yelling for help on the night shift around 1:10 a.m., R1 was discovered in her room lying on the floor on her right side. R1 had complaints of severe lower extremity pain, primarily on her right lower extremity (RLE) but upon focused assessment had more difficulty moving her left lower extremity (LLE). R1 was alert and oriented and stated that she hit her head, and a lump was noted to the back of her head. Family member (FM)-A was contacted due to R1 reports of severe pain and was agreeable to emergency transport to hospital for further assessment. R1 was transported from the facility to the hospital around 2:50 a.m. for further assessment.

R1's Event report dated 8/12/24, included the aforementioned information pertaining to R1's fall. Additionally noted R1 was unsure what she was doing prior to fall but verbalized needing to use the restroom.

R1's progress note dated 8/12/24 at 7:04 a.m., identified a call was received from the hospital indicating R1 will be sent back via ambulance with a right fibular fracture, proximal to R1's

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F 689	Continued From page 3 ankle. A Facility Investigation, completed 8/15/24, IDT team reviewed fall on 8/12/24 that occurred at 1:10 a.m. Fall was not witnessed, and staff were alerted to fall by resident calling out in pain. R1 was located lying on the floor next to her bed and could not state what she was doing but did verbalize needing to use the restroom. R1 had not been offered toileting at 11:00 p.m. by NA-A as the care plan stated and R1 was not checked on at midnight by NA-A during rounding. Interventions were to remove pillow top mattress, switch rooms so R1 could be closer to center of unit and not at end of hall so staff could see her more frequently. Toileting changed to every 2-3 hours. Paddy light was added as R1 stated she was confused by the red button call light. Care plan updated to have transfers with assist of two and ceiling track. Physical therapy (PT) and occupational therapy (OT) was ordered by provider. Family approved of interventions. Care plan, group sheets, and communication book updated. R1 had an appointment with certified nurse practitioner (CNP)-A to review falls in one week and review pain management on 8/13/24. Education was provided to NA-A regarding care plan stating resident was to be toileted at 11:00 p.m., as this did not occur and of the importance of visualizing resident during rounds. NA-A last day of employment was 8/16/24 as separation of employment. During a phone interview on 11/4/24 at 2:48 p.m., NA-A stated she remembered the night R1 fell and stated she was very busy that night and did not make it into R1's room at 11:00 p.m., to toilet her, also stated she did not get to R1 on rounds at 12:00 a.m. NA-A stated she was on a different	F 689		

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F 689	Continued From page 4 floor when R1 fell on 8/12/24. NA-A stated someone at that facility did educate her about the importance of following the residents care plan and the importance of rounding timely. During a phone interview on 11/4/24 at 2:56 p.m., licensed practical nurse (LPN)-A stated she was the nurse that worked the floor the night R1 fell. LPN-A stated it was her first time working at the facility and had been walking to another residents room to give some medications when she heard R1 calling for help. LPN-A stated she asked another nurse for help due to being unfamiliar with R1 and R1 ended up being sent to the ER and came back with a fractured lower right leg. LPN-A stated R1 was in a lot of pain, and she had not been in R1's room prior to the fall. During an interview on 11/4/24 at 2:13 p.m., registered nurse (RN)-A indicated R1 fell on 8/12/24 at 1:10 a.m., due to needing to use the bathroom which resulted in a trip to the ER and a fractured right fibula. RN-A indicated nursing assistant (NA)-A did not offer toileting at 11:00 p.m. per R1's plan of care and this could have prevented the fall. NA-A was educated on the importance of following the care plan. RN-A stated we review falls in interdisciplinary Team (IDT) meeting Monday through Friday, we will look at all of the information documented to ensure a root cause, appropriate interventions are in place and to ensure the care plan was being followed. RN-A stated on Wednesdays we review all falls for the week to ensure the interventions we put in place remain appropriate, if not we may remove intervention and add a new one. During an interview on 11/4/24 at 3:08 p.m.,	F 689		

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F 689	Continued From page 5 director of nursing (DON) and regional nurse consultant (RNC)-A reviewed R1's facility fall investigation and identified a comprehensive fall investigation was completed to include a summary of events, interviews, resident assessment, description of immediate resident protections, notifications, causal and/or contributing factors, and an overall detailed summary. DON and RNC-A indicated on 8/12/24, R1's care plan for toileting was not followed resulting in a fall with a fracture. DON and RNC-A indicated education was completed with NA-A on the importance of following the care plan and the importance of rounding timely along with expectations. DON and RNC-A indicated all falls are reviewed Monday through Friday to ensure interventions are in place and to ensure the care plan was followed. DON and RNC-A further indicated they meet every Wednesday to ensure all fall interventions are appropriate. The deficient practice was corrected on 8/15/24, after the facility implemented a plan that included the following actions: R1 was immediately assessed and fall protocols were followed. Upon R1's change in pain and mobility status, R1 was transferred to the ED. Facility investigation was coordinated with interviews of staff and R1, along with care plan review. NA-A was provided verbal coaching and education after it was determined she failed to follow R1's plan of care. The facility reviewed falls at IDT Monday through Friday to ensure the care plan was followed for each fall and reviewed all falls weekly on Wednesdays to ensure current prevention interventions that were in place were effective. The facility was free of additional falls after 8/15/24 related to failure to follow plan of care. The corrective actions were verified through documentation review and staff	F 689		

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F 689	Continued From page 6 interviews. Facility policy, "Comprehensive Assessments and Care Planning," revised 9/27/23, identified a purpose to provide a comprehensive person-centered interdisciplinary care assessment of the resident's condition, in order to develop consistent quality care that will attain or maintain the highest practicable physical, mental, and psychological functioning possible, a facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State ...11. All person-centered care plan interventions will be implemented by qualified personnel. Interventions may be communicated through the electronic health record, resident profile, assignment sheets, and/or verbal communication ... Facility policy, "Integrated Fall Management," reviewed 9/2023, identified the Purpose: Fall risk assessment, identification, and implementation of appropriate interventions as necessary, to maintain resident safety, prevent falls and reduce further injury from falls. Residents with risk for falling will have interventions implemented through the resident centered care plan.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 18, 2024

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

Re: Event ID: 0YJL11

Dear Administrator:

The above facility survey was completed on November 4, 2024, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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	00955	A. BUILDING: _____ B. WING _____	C 11/04/2024

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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 10/31/24 and 11/4/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was reviewed: H52337220C (MN105716). NO licensing orders	2 000		

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2 000	Continued From page 1 were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		