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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 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 immediate corrective action, so the deficient practice was issued at past non-compliance. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], 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 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. (continued on next page)

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.

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

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	245233	A. Building B. Wing	11/04/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 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. [NAME] 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 floor when R1 fell on [DATE]. 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. (continued on next page)

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/4/24 at 2:13 p.m., registered nurse (RN)-A indicated R1 fell on [DATE] 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., 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 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.