Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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	02/13/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 51578 Based on observation, interview, and record review the facility failed to ensure a dignified dining experience for residents who required assistance with eating. This had the potential to affect all residents in the facility who were dependent on staff for their intake of nutrition. Findings include: During an observation of the main floor dining room on 2/10/25 at 5:08 p.m., nursing staff were standing while feeding residents. The staff would move from table to table to assist different residents and were found to not have engaged with the residents during the meal. During an observation on 2/11/25 at 11:55 a.m., nursing staff were standing during lunch meal and moving from resident to resident. During an observation on 2/12/25 at 12:22 p.m., the 5th floor common area was used for meals. Nursing assistant (NA-C) was assisting residents with their meals while standing. NA-C would call out, out loud asking if the residents needed any assistance. During an interview on 2/12/25 at 12:32 p.m., NA-E explained most of the residents need some sort of assistance during meals and most days there are two NA's available to help assist the residents on 5th floor. NA-E said at times when there is only one NA they may stand to assist the resident to eat. NA-E indicated it's a staff preference if nursing staff choose to stand or sit while helping residents during meals. During an interview on 2/12/25 at 2:04 p.m., the culinary director (CD) stated they have an average of 20-25 residents who eat in the main dining room. Those who do not come to the main dining area use the common area on their floor or receive a tray and eat in their rooms. CD indicated the dietary staff do not assist residents with meals. CD verified staff should not be standing while assisting residents with meals and can be considered a dignity concern. During an observation on 2/13/25 at 8:22 a.m., during breakfast in the main dining room several nursing staff were standing while feeding residents. NA-B, licensed practical nurse (LPN-B) and NA-A were observed not sitting next to the residents who needed assistance with their meal. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/13/2/5 at 9:03 a.m., Regional Director of Nursing (RDON) indicated the expectation during meal times would be to have nursing staff sit at the tables with the residents, assist the resident with food , such as cutting the food up, and offer them the choice of how they would like to consume their meal. RDON verified the facility has several residents who need more assistance with eating and drinking during meals. Nursing staff need to sit in order to provide time and respect to the resident. RDON confirmed nursing staff need to focus on one resident at a time. Facility policy titled Assistance with Meals dated 2018, included nursing staff and associates will serve meals to resident and assist those who require assistance with eating. Residents who cannot feed themselves will be assisted with attention, safety, comfort, and dignity.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51578 Based on observations, interview, and document review the facility failed to ensure compression stocking were applied as ordered to help with edema of the lower extremities for 1 of 1 resident (R10) reviewed for activity of daily living . Findings include: R10's annual Minimum Data Set (MDS) assessment dated [DATE], included R10 cognitive status was intact and required minimal assistance with activities of daily living. R10's face sheet dated 11/17/23 included diagnoses of disorders of veins, localized edema, essential hypertension, history of acute embolism and thrombosis related to deep veins of bilateral lower extremities, cerebral infarction (stroke or bleeding in the brain), and generalized weakness. R10's medical record included, an order to apply compression stockings daily every a.m. and remove at HS (at night). During an observation on 2/10/25 at 1:15 p.m., R10 was resting in a recliner noted to have edema bilaterally to lower extremities. During an interview on 2/10/25 at 1:31 p.m., R10 said both ankles were swollen, and could not apply the compression stockings themselves and staff do not always put them on in the mornings. R10 stated has asked for assistance to apply the compression stockings, however staff forget to help when getting dressed. During an observation on 2/11/25 at 11:16 a.m. R10 did not have compression stockings on to bilateral extremities. During an interview on 2/11/25 at 11:18 a.m., R10 stated staff did not offer to help put them on and nobody asked about whether they were in place. R10 said the reasons she needed them is due to medical condition and doctor's request. During an interview on 2/11/25 at 12:12 p.m., licensed practical nurse (LPN-C) verified there was a physician's order and staff are supposed to assist R10 in the morning and take them off at night. LPN-C explained R10 usually gets dressed independently and the nursing staff assist R10 as needed. During an interview on 2/12/25 at 2:20 p.m., regional director of nursing (RDON) verified there was a current order for the compression stockings. RDON indicated the expectation were for nursing staff to following through with assisting R10 with compression stockings. A policy on edema/ compression stockings was asked for and not provided.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51379 Based on observation, interview and document review, the facility failed to ensure routine grooming was completed who was dependent on staff for personal cares for 1 of 1 resident (R62), reviewed for activities of daily living (ADL)'s . Findings include: R62's minimum data set (MDS) assessment dated [DATE], indicated mild cognitive impairment and was dependent on facility staff to complete personal hygiene tasks. R62's face sheet included the diagnosis of peripheral autonomic neuropathy (nerve damage), thoracic spondylosis (a condition that affects the middle part of your spine, causing pain, stiffness, and nerve compression), generalized muscle weakness, and hemiplegia (paralysis of one side of the body) R62's care plan dated 1/24/25 indicated a self-care deficit related to personal hygiene and bathing and required substantial assistance from facility staff. During observation and interview on 2/10/25 5:08 p.m., R62 had facial hair present on the right upper lip and chin. Right upper lip contained a patch of black hairs, and the chin hair contained several medium-length chin hairs and one long hair approximately 1.25 inches in length. R62 stated she does not like the lip or chin hair and would like it removed. During interview on 2/12/25 7:23 a.m., nursing assistant (NA)-F stated nurses on each floor enter the tasks in the task administration record (TAR), this includes things like ADL's, bathing, and hygiene. When NA's start their shift, they get a printout of the care areas to be completed during their shift. NA-F confirmed residents who have facial hair is shaved on bath days. During interview on 2/12/25 7:25 a.m., licensed practical nurse (LPN)-B stated the health unit coordinator enters tasks in the TAR for residents. This could be based on physician orders or nurse direction. Furthermore, registered nurse (RN)-E can enter tasks in the admission care plan and ensures the provider orders are done. If a new care plan or task needs to be ordered, then the floor nurse will enter the task. LPN-B confirmed if the order or care plan isn't entered, then the NA's or other staff don't know they need to complete the task. For hygiene cares, the resident can ask for anything specific or if someone sees they need care then they can enter a task for the cares needed. If she saw a female resident with facial hair, she would discuss the hygiene with the resident then enter an order. During an observation and interview on 2/12/25 8:12 a.m., RN-F stated R62 receives her bath on Thursday's PM shift and this would be when they do hygiene and facial hair removal. RN-F said R62 had a bath last Thursday and confirmed resident has prominent facial hair on upper lip and chin. An undated activities of daily living policy stated residents who are unable to carry out ADL's independently, will receive assistance with hygiene, mobility, elimination, dining, and communication.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 51578 Based on observation, interview and document review, the facility failed to replace and maintain oxygen tubing for 2 of 2 residents (R32 and R65) reviewed for respiratory care. Findings include: R32's Minimum Data Set (MDS) assessment, indicated severe cognitive impairment and received supplemental oxygen. R32's order report dated 1/4/2025, indicated diagnoses of primary emphysema (chronic lung condition that causes shortness of breath), respiratory failure, and hypoxemia and R32 active orders instructed staff to deliver continuous oxygen and to titrate (continuously measure and adjust the balance) amount to maintain oxygen saturation above 88%. During an observation on 2/10/25 at 1:44 p.m., R32's oxygen tubing was dirty under the nasal area. This tubing was hooked up to a concentrator with a long extension and tied in a knot with R32's wheelchair sitting on top of the tubing. During an interview on 2/11/25 at 10:45 a.m., licensed practical nurse (LPN-C) explained the process for changing and maintaining oxygen tubing. The current process was a scheduled task during a nursing shift and included changing the tubing weekly, if tubing was visibility dirty, or there were any concerns on tubing integrity. During interview on 2/11/25 at 10:52 a.m., LPN-C verified R32's oxygen tubing was in a knot and should be changed for sanitary reasons. During an interview on 2/11/25 at 11:24 a.m., nursing assistant (NA-B) stated R32 was usually wheeled out of her room with the oxygen tubing still hooked up to the concentrator in resident's room. NA-B was not aware of the process for changing oxygen tubing or why R32 was not hooked up to a portable oxygen tank. R65 R65's MDS indicated severe cognitive impairment and received supplemental oxygen. R65's order report dated 1/16/25, indicated diagnoses of dementia, anxiety, heart failure, hypoxemia, recurrent pneumonia, acute respiratory failure due to hypoxemia, and hypertension. R65's active orders dated 1/20/25, directed staff to deliver continuous oxygen via nasal cannula and to titrate amount to maintain oxygen saturation between 88-92%. Orders further directed staff to deliver continuous oxygen at 2-3 liters per minute via nasal cannula at bedtime, and to titrate amount to keep oxygen sats above 88%. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/11/25 at 12:35 p.m., R65's oxygen tubing was lying beside resident on the floor. R65 was self-propelling in their wheelchair around facility. R65 took their oxygen nasal cannula on and off several times during observation. R65's oxygen tubing was hooked up to a portable oxygen tank and was not labeled when last changed. During an interview on 2/12/25 at 8:54 a.m., RN-A reviewed R65's care plan and orders. RN-A stated R65 rolls self in wheelchair up and down the hallway and was placed on a portable oxygen tank. RN-A explained it would be a concern if R65's oxygen tubing was dirty and not labeled on the portable tank. RN-A stated because R65 moves around facility while taking oxygen tubing on and off as needed, this could potentially lead to infection control concern. During an interview on 2/12/25 at 10:03 a.m., RN-A reviewed R23's plan of care with oxygen tubing. RN-A stated R32 was able to push herself in a wheelchair and move around the room. RN-A confirmed R23 should not have been hooked up to a long extension tube for sanitary and safety concerns. RN-A explained the facility's oxygen policy indicating the oxygen tubing should be changed and labeled weekly. RN-A's expectation was staff should not keep residents on long extension tubing, should change the tubing if it is dirty, and the recommendation would be to place R23 on a portable tank. During an interview on 2/12/25 at 11:41 a.m., infection preventionist (IP) indicated the facility was working on a process of updating the labeling of oxygen tubing. IP reviewed current process as staff chart in the medication administration record (MAR) or treatment administration record (TAR) when they change the tubing. IP stated for residents who have long extension tubing, they should be placed on a portable oxygen tank for sanitary reasons, safety concerns, and it was a standard of care. IP explained if R32's wheelchair was on the oxygen tubing there would be a concern about tubing integrity. IP was aware of R65's habit of taking the oxygen tubing on and off and stated her expectation would be to watch it closely for infection control. During interview on 2/13/25 at 10:46 a.m. director of nursing (DON) and regional director of nursing (RDON) reviewed the current process of changing oxygen tubing and providing a sanitary, clean standard of care. The facility expectation was residents should be placed on portable oxygen tanks with clean tubing. The task should be documented in the MAR or TAR when changed every week and/or changed when other concerns such as tubing integrity or infection prevention needs are met. Facility policy titled Oxygen Therapy dated 2017, includes residents were to be assessed to ensure their respiratory needs are being met. Residents identified in need of oxygen therapy will have interventions and equipment which followed manufacturer recommendations for safe handling, cleaning, humidification, storage, and dispensing, maintenance of equipment and consistent federal, state, and local laws and regulations.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51578 Based on observation, interview, and document review, the facility failed to maintain separately locked, permanently affixed compartments for storage of controlled drugs for 4 of 4 observed medication storage areas during a facility wide remodel. Findings include: During an observation and interview on 2/13/25 at 9:08 a.m., licensed practical nurse (LPN)-B identified the current refrigerator used to store medication on the 2nd floor was locked. The locked refrigerator was not affixed to any permanent surface and was in a temporary nurse's station in the open while the facility was in the middle of a remodel. LPN-B identified the medications in the refrigerator contained flu shot, insulin pens, tuberculin, and Ativan (antianxiety). LPN-B stated the nurses are the ones who check the expiration dates and refill the refrigerator. During observation of the 3rd, 4th, and 5th floor medication storage areas, it was found each had the same type of refrigerator located in a temporary nurse's station as found on the 2nd floor. The nursing staff carry a key to the locked refrigerator which was noted to contain some of the same medications noted above. In order to gain access to the area, staff need to walk through a temporary half-height wooden door noted not to lock. behind this half-door is an where the refrigerator is located. Any staff, visitor, or construction worker could have access to this area . During an interview on 2/13/25 at 9:08 a.m., LPN-B stated there is an Emergency Kit located on the 3rd floor, but that was the only double locked medication storage also containing controlled medications. During an interview on 2/13/25 at 10:50 a.m., director of nursing (DON), regional director of nursing (RDON) and administrator was present. The RDON explained the current process for medication storage is to have most medication in the locked carts. The facility has a medication storage refrigerator on each floor behind the temporary nurses' station and a locked cabinet for the emergency kit. Facility policy titled, Controlled Substance Storage dated 4/1/19, included medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility in accordance with federal, state, and other laws and regulations. The procedure for schedule II medications or higher are stored in a permanently affixed, double -locked compartment separate from all other medications per regulation. Controlled substances that require refrigeration are stored within a locked box within the refrigerator. This box must be kept attached to the inside of the refrigerator.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37908 Based on observation, interview and record review, the facility failed to appropriately clean resident medical equipment after use and place barrier between resident high touch surface and resident multiuse basket. This had the potential to affect all resdient's who received blood glucose monitoring. In addition, the facility failed to ensure proper use of personal protective equipment (PPE) during cares for 1 of 3 residents (R36) reviewed for enhanced barrier precautions (EBP). Findings include: During medication administration on 2/10/25 at 3:47 p.m. registered nurse (RN)-C set up medications for R35. R35 also required to have a blood sugar checked. RN-C had a basket containing the following: lancets (device to puncture the skin for blood sample), test strips, sharps containers, cotton balls and on top was a glucometer (machine to get results of the blood sample). Once in R35's room RN-C placed the basket on a chair then moved the basket from the chair to the resident tray table with out placing a barrier between the tray table and the basket. After RN-C completed the glucose check RN-C then placed the glucometer on the tray table with out any barrier. When completed RN-C placed the glucometer on the supplies in the basket with out cleaning. At 4:01 p.m. RN-C prepared medications for R3 and had indicated R3 also needed a glucose checked. RN-C had all supplies and medications in hand and ready to enter R3's room when surveyor intervened and asked the nurse to review things prior to going in the room. RN-C placed items back on top of medication cart. RN-C said she should wipe the machine down before using it again. RN-C was looking for the cleaning wipes, surveyor pointed to them on a near by cart. During an observation on 2/10/25 at 4:19 p.m., RN-D prepared insulin for R55. RN-D obtained a basket from a near by treatment cart, containing glucometer, lancet, sharps container and entered R55's room and placed the basket on R55's tray table with out placing a barrier down. RN-D exited the room and placed the glucometer and basket on the treatment cart and walked away. Surveyor asked if there was anything he missed. Surveyor asked if he would normally clean the equipment. RN-D said he forgot. During an email communication dated 2/12/25 at 4:16 p.m., infection preventionist (IP) included the infection tracker and indicated the facility just got out of a Norovirus outbreak. During a phone interview on 2/13/25 at 10:28 a.m., IP indicated the facility uses a shared glucometer for glucose checks and would expect the resident equipment to be cleaned in between residents. There is cleaners on each floor. IP indicated she completed a observation recently and identified a staff not placing a barrier down between the basket and resident tables. IP said a tray table is a high touch surface and should have a barrier if setting something down on it like a basket. IP indicated if staff are not using a barrier there is a potential for spread in the facility. 49893 Resident #36 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R36's quarterly Minimum Data Set (MDS) assessment, dated 11/5/24, indicated R36 was cognitively intact and had a g-tube (tube inserted into the stomach used to provide nutrition). R36's diagnoses list includes stroke, gastronomy (hole placed through the skin into the stomach). R36's provider orders included Osmolite 1.5 (brand of liquid nutrition) at 150ml/hr from 9 hours, clean are around gastric tube with wound cleanser or normal saline, apply Calmoseptine (cream to protect the skin), apply split gauze. It also included give meds through gastric tube via liquid form or pill form to be crushed. All medications can be crushed and given together per resident preference. R36's careplan indicated R36 required enhanced barrier precautions (EBP) related to g-tube. Post clear signage on the door or wall outside the resident's room indicating type of precautions and required PPE. Staff to apply gloves and gowns prior to facility-identified high contact care activities, discard PPE in designated locations following activities and sanitize hands after PPE removal. During observation and interview on 2/11/25 at 8:21 a.m. outside R36's room was a sign indicating EBP in addition to a set of drawers containing gowns and gloves. Licensed practical nurse (LPN)-A entered R36's room with a plastic cup containing a colored liquid. LPN-A washed hands and applied gloves. Without donning a gown, LPN A removed dressing from R36's g-tube site and cleaned area with wound wash and a gauze sponge. LPN-A removed gloves, sanitized hands, and applied a new set of gloves. A barrier cream was applied to the skin surrounding the g-tube and a new dressing was applied. LPN-A then administered the colored liquid into the G-tube, flushed the tube with water, removed gloves, and threw away garbage. During an interview, LPN-A stated EBP is important because of exposure due to R36's tube. LPN-A stated gloves were the only requirement for EBP. LPN-A was unaware if the facility provided any specialized training related to EBP. During interview on 2/12/25 at 1:08 p.m., nursing assistant (NA)-A stated staff are required to do yearly online training and in person training regarding EBP. During an interview on 2/12/25 at 1:26 p.m., the infection preventionist (IP) stated appropriate PPE is required for all high contact cares, including administering medications via G-tube, G-tube site care, changing clothing, and bathing for residents on EBP. The IP confirmed gown and gloves should be during R36's dressing change and medication administration. A policy titled Enhanced Barrier Precautions revised 4/1/24, indicated Enhanced Barrier Precautions (EBP) expands the use of Personal Protective Equipment (PPE) beyond situations in which exposure to blood and body fluids is anticipated. It also refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. In a grid listing the types of transmission-based precautions and when/how to implement them, the policy indicated Enhanced barrier precautions is implemented for residents with indwelling medical devices, including feeding tubes). Staff are instructed to don gloves and a gown prior to any high contact care activity. High contact care activity included indwelling medical device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator.