| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245233 | A. Building<br>B. Wing | 05/21/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Saint Anne Extended Healthcare | 1347 West Broadway Street<br>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 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>Based on observation, interviews, and record review, the facility failed to ensure once opened, a bottle of tuberculin solution (solution used in intradermal skin tests to detect tuberculosis infection) was labeled in accordance to professional standard (an opened multidose vial of tuberculin PPD must be discarded 30 days after the first puncture). Additionally, the facility failed to ensure 1 of 1 resident's (R32) Lantus (insulin glargine) pen was dated once opened. Findings include: During an observation and interview on 05/18/26 at 2:09 p.m., of the fourth-floor medication refrigerator, a bottle of tuberculin solution approximately three quarters used, a light blue label on the bottle indicated, discard 30 days after opening. Close inspection of the bottle showed no open date. Licensed practical nurse (LPN)-A, present during the observation confirmed, the open bottle of tuberculin solution was not dated once opened and stated, the bottle should not have been in the refrigerator. During an interview on 05/21/26 at 8:44 a.m., registered nurse, case manager (RN)-B stated, tuberculin solution was used for residents on the fourth floor, when needed for floors one, two, three, five and expected an opened bottle of tuberculin solution discarded 30 days after opening. During an observation and interview on 05/20/26 at 9:15 a.m., the fourth floor second medication cart contained a Lantus insulin pen being used for R32. A yellow label on the insulin pen indicated, discard 28 days after opening. LPN-A present during observation confirmed, R32's insulin pen was not dated, and the pen was last used on 5/19/26 at 6 :00 p.m. During an interview on 05/21/26 at 8:48 a.m., RN-B confirmed, Lantus pen was to be dated once opened and discarded 28 days after opening. Facility policy for medication, treatment, and medical supplies storage requested, not received at this time. |

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 0790<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide routine and 24-hour emergency dental care for each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure routine dental services were provided or offered to promote oral hygiene and reduce the risk of complication (i.e., further breakdown, oral pain) for 1 of 1 residents (R9) reviewed for dental hygiene and services.Findings include: R9's annual Minimum Data Set, dated [DATE] identified impaired cognition and required assistance with oral hygiene. In addition, R9 with diagnoses of dementia and anxiety.R9's physician orders dated 7/22/25 state, Optometry, Audiology, Psychology, Dental, and Podiatry consults to evaluate and treat as indicated.R9's care plan dated 1/14/26 identified, need assistance with dental care d/t dementia. I have an upper partial denture.R9's electronic medical record (EMR) lacked evidence of a progress note or referral or provided a consultation for dental services.During observation and interview on 5/18/26 at 2:03 p.m., R9 was sitting in wheelchair in her room on the locked memory care unit. She had intact teeth of upper and lower jaw. R9 stated she did not have dentures and that staff had not asked her about dental appointments. Furthermore, R9 stated she could not recall the last time she visited a dentist.During interview with social services (SS)-A on 5/19/26 at 12:57 p.m., SS-A stated the facility arranges a contracted dental service annually for all of the residents and that I believe our infection control preventionist (IP) coordinates it. SS-A stated her department had nothing to do with asking residents or their guardians about routine dental visits.During interview with registered nurse (RN)-A on 5/19/26 at 1:04 p.m., RN-A stated she was the nurse manager for the memory care unit at the facility. RN-A stated she was not involved in asking for or coordinating routine dental visits.During interview with the regional director of clinical services (RC)-C and IP on 5/19/26 at 1:31 p.m., IP stated she sends out an email annually to family members and guardians to ask if they would like to be seen by a dentist for routine care. RC-C stated the facility did not have a process to identify and document refusals or when the last dental visit was done. Both verified that it was possible and likely that residents could get missed for setting up routine dental visits and R9's EMR failed to identify if she or her guardian were asked to be seen by a dentist.During interview with R9's guardian and power of attorney (FM)-A on 5/19/26 at 12:10 p.m., FM-A stated he was unaware of last time R9 was seen by a dentist.During interview with director of nursing (DON) on 5/21/26 at 10:04 a.m., DON verified R9 EMR failed to show that she was offered or provided routine dental visits. DON stated, [R9] should be asked and it should be documented but it was not.Facility policy titled Dental Services, reviewed 4/2021, state, Routine and emergency dental services are provided to our residents and All dental services provided are recorded in the resident's medical record. |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain dental services for each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure routine dental services were provided or offered to promote oral hygiene and reduce the risk of complication (i.e., further breakdown, oral pain) for 1 of 1 residents (R29) reviewed for dental hygiene and services. Findings include: R29's quarterly Minimum Data Set, dated [DATE] identified R29 with significantly impaired cognition, and dependent on staff for all cares including oral hygiene. In addition, R29 with diagnoses of neurocognitive disorder with Lewy body (dementia)fibromyalgia, and arthritis.R29's Dental Consult, dated 6/27/24 identified, Multiple broken teeth. Recommend extract any teeth that become symptomatic.R29's care plan with edit date of 4/9/2020 identified, Dental appointments per resident or resident representative preferences.During interview with R29's emergency contact (FM)-B on 5/20/26 at 12:15 p.m., FM-B stated he expected the facility to arrange for routine dental services and could not recall the last time R29 was seen by a dentist. FM-B stated, [R29] did not have many teeth left and wanted her to be seen.During interview with social services (SS)-A on 5/19/26 at 12:57 p.m., SS-A stated the facility arranges a contracted dental service annually for all of the residents and that I believe our infection control preventionist (IP) coordinates it. SS-A stated her department had nothing to do with asking residents or their guardians about routine dental visits.During interview with registered nurse (RN)-A on 5/19/26 at 1:04 p.m., RN-A stated she was the nurse manager for the memory care unit at the facility. RN-A stated she was not involved in asking for or coordinating routine dental visits.During interview with the regional director of clinical services (RC)-C and IP on 5/19/26 at 1:31 p.m., IP stated she sends out an email annually to family members and guardians to ask if they would like to be seen by a dentist for routine care. RC-C stated the facility did not have a process to identify and document refusals or when the last dental visit was done. Both verified that it was possible and likely that residents could get missed for setting up routine dental visits. In addition, both stated R29's EMR lacked evidence of a follow-up dental visit to address possible extraction after the 6/27/24 visit.During interview with director of nursing (DON) on 5/21/26 at 10:04 a.m., DON verified R29's EMR failed to show that she was offered or provided routine dental visits. DON stated, [R29] should be asked and it should be documented but it was not.Facility policy titled Dental Services, reviewed 4/2021, state, Routine and emergency dental services are provided to our residents and All dental services provided are recorded in the resident's medical record. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure food stored in a unit refrigerator were labeled, dated and discarded properly. Additionally, facility failed to ensure proper food storage for 1 of 1 resident refrigerator that contained undated and unlabeled food.Findings Include:During an observation on 05/20/26 9:05 a.m., the fourth-floor kitchen refrigerator contained the following items: 3 clear sandwich size bags with egg salad sandwiches labeled with room number and undated, 1 small size of uncovered paper bowl of [NAME] tot and a taco wrapped in brown paper from taco [NAME], not labeled and undated. 3 small (2 .25 oz) plastic portion cups, black container, clear covering, holding a creamy and medium consistency substance, not labeled and undated. A medium size (16 oz) food container with a red lid, holding a mixture of ground brown meat, and a reddish liquid labeled with a room number and dated 5/14/26. During an interview on 05/20/26 9:05 a.m., nursing assistant (NA)- A, confirmed food items in the refrigerator were eggs salad sandwiches undated, ranch dressings not labeled and undated, [NAME] tot and a taco from Taco [NAME] not labeled and undated, a medium size food container of goulash dated 5/14/26. NA-A stated dietary staff was responsible for monitoring the kitchen refrigerator daily for proper food labeling, dating, and the removal of outdated food items.During an interview 05/20/26 9:20 a.m., licensed practical nurse (LPN)-A stated, any food item placed in the kitchen refrigerator needed to be dated and labeled, however dietary staff was responsible for monitoring for proper labeling, dating and the removal of outdated food items. During an interview on 05/20/26 at 10:30 a.m., culinary supervisor (CS) stated, dietary staff was responsible for monitoring the refrigerators in the kitchen areas for proper labeling, removal of outdated food items and the task was completed daily. Facility Policy Titled, Safe Food Storage and Handling for Food Brought in, last reviewed August 20219 indicated All food stored in the refrigerator/freezer units should be in covered, seamless containers or otherwise suitably protected with date the product was given to the community for storage, used by date (max of 3 days) name and room number of resident. Containers should be arranged so that free circulation of air is always allowed. Storage of large quantities of food in oversized containers should be avoided. |