DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 4, 2026

Administrator
Saint Anne Extended Healthcare
1347 WEST BROADWAY STREET
WINONA, MN 55987

RE: CCN:245233
Cycle Start Date: May 21, 2026

Dear Administrator:

On May 21, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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:

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

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 August 21, 2026 (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 November 21, 2026 (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)

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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June 4, 2026

Administrator
Saint Anne Extended Healthcare
1347 WEST BROADWAY STREET
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Re: State Nursing Home Licensing Orders
Event ID: 1F3520-H1

Dear Administrator:

The above facility survey was completed on May 21, 2026 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 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 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:

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245233	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/19/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Anne Extended Healthcare	**1347 WEST BROADWAY STREET , WINONA, Minnesota, 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
K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/19/2026. At the time of this survey, ST ANNE EXTENDED HEALTHCARE was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		06/17/2026

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245233	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/19/2026**

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. ST ANNE EXTENDED HEALTHCARE a 6 story building with partial basement. The building was constructed 1962 and was determined to be of Type II (222) construction. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 99 beds and had a census of 89 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: = = =	K0000		06/17/2026

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K0000 Bldg. 01	Continued from page 2 SNF is separated by 2 hour rated fire wall from Assisted Living.	K0000		06/17/2026
K0222 SS = F Bldg. 01	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.	K0222	Facility has systems in place to ensure proper functioning of the controlling device of an egress door. The keypad for the 5th floor East stairwell door was repaired on 5/19/2026. All keypads were tested for proper functionality on 5/19/2026. Keypads for egress doors are included on the monthly EVS audit checklist. Results of audit checklist will be provided to the Director of Environmental Services for review and signature. Any issues will be immediately addressed. Re-education provided for all staff include importance of ensuring proper functioning of egress door controlling devices and reporting malfunctioning devices to EVS immediately. Re-education will also be discussed at Safety Committee. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction. Completion Date: 6/17/2026	06/17/2026

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K0222 SS = F Bldg. 01	Continued from page 3 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain functional operation of the controlling device of an egress door per NFPA 101 (2012 edition), Life Safety Code, section(s) 19.2.2.2.4, 7.2.1.6.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/19/2025 at 10:00 AM, it was revealed by observation that a 5th FL, stairwell exit door did not release upon test. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0222		06/17/2026
K0291 SS = F Bldg. 01	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and	K0291	Facility has systems in place to ensure emergency light testing is being completed monthly and documented. Per the attached documentation, all emergency light testing was completed during the fiscal year. Documentation related to testing results has been attached to this plan of correction. At the time of the survey, the documentation was not in facility's Fire Book, it was maintained in a separate binder. Emergency light testing will continue on a monthly	06/17/2026

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K0291 SS = F Bldg. 01	Continued from page 4 staff interview, the facility failed to maintain, test, and inspect the emergency lighting fixtures per NFPA 101 (2012 edition) Life Safety Code, sections 19.2.9.1, 7.9.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/19/2026 between 9:30 AM to 3:00 PM, it was revealed by a review of available documentation that no documentation was available to confirm emergency light testing is being completed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0291	Continued from page 4 basis. Results of testing will be brought to Safety Committee. Regulation was reviewed with Director of Environmental Services and education will be provided to all plant operations staff on where this separate binder is kept. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction. Completion Date: 6/17/2026	06/17/2026
K0324 SS = F Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain proper	K0324	Facility has systems in place to ensure and confirm that 6-month inspections of the Ansul type fire suppression system are being completed. Per the attached documentation, Ansul type fire suppression system was completed and facility is providing documentation of testing results. This was last completed on 1/28/26. At the time of the survey, the documentation had not been obtained from the vendor and placed in facility's Fire Book for Fire Marshal review. Director of Environmental Services or their designee will perform audits to review and track inspection reports on a quarterly basis. Regulation was reviewed with Director of Environmental Services and education will be provided to all plant operations staff on obtaining inspection reports and placing them in the Fire Book. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction. Completion Date: 6/17/2026	06/17/2026

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K0324 SS = F Bldg. 01	Continued from page 5 inspection and safety documentation in accordance with NFPA 101 (2012 edition), Life Safety Code, section(s) 9.2.3, 19.3.2.5.3, NFPA 96 (2014 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section(s) 4.1, 4.1.5, 11.2. This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 05/19/2026 between 9:30 AM to 3:00 PM, it was revealed by a review of available documentation that no documentation was available to confirm that 6-month inspections of the ansul type fire suppression system are being completed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0324		06/17/2026
K0363 SS = F Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are	K0363	Facility has systems in place to ensure corridor doors serving bariatric resident rooms are maintained per NFPA 101. Rooms 423,323, and 223 which are double door assembly serving bariatric resident rooms were equipped with proper latching hardware and gasketing to prevent the passage of smoke. Work was completed on 6/9/2026. Walk through of facility to inspect all resident room double doors to ensure proper latching and hardware and gasketing was completed on 5/19/2026. Education for Environmental Services staff will include requirement of appropriate gasketing on double doors to prevent passage of smoke. Inspection of all double doors to ensure proper gasketing serving bariatric rooms was added to safety checklist. Results of safety checklist inspections will be provided to Director of Environmental Services for review and signature. Any issues will be immediately addressed and brought forward to Safety Committee for discussion. Annual door inspection program will be added to safety checklists.	06/17/2026

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K0363 SS = F Bldg. 01	Continued from page 6 allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors serving bariatric resident rooms per NFPA 101 (2012 edition), Life Safety Code, section(s) 19.2.2.2.4, 7.2.1.6.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 05/19/2026 between 9:30 AM to 3:00 PM, it was revealed by observation that the following double door assembly serving bariatric resident rooms were not equipped with proper latching hardware and gasketing to prevent the passage of smoke - RML 423 / RML 323 / RML 232. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0363	Continued from page 6 Director of Environmental Services or their designee is responsible for monitoring of this plan of correction. Completion Date: 6/17/2026	06/17/2026
K0374 SS = F Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is NOT MET as evidenced by:	K0374	Facility has systems in place to ensure all smoke barrier doors close and seal properly. All smoke barrier doors on 2nd, 3rd, and 4th floor were inspected, new seals placed on doors and doors were adjusted on 06/01/2026. Annual testing will occur prior to September 19, 2026 per regulation. This task has been added to TELS preventative maintenance system. Smoke barrier doors are included on the safety audit checklist to ensure proper closing and sealing. Safety Committee will be involved in safety inspections. Results of safety checklist inspections will be provided to Director of Environmental Services for review and signature. Any issues will be immediately addressed and brought forward to Safety Committee for discussion.	06/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245233	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/19/2026**

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K0374 SS = F Bldg. 01	Continued from page 7 Based on observation and staff interview, the facility failed to test, maintain, and inspect the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4 These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 05/19/2026 between 9:30 AM to 3:00 PM, it was revealed by observation that the 4th , 3rd, and 2nd Floor(s) - smoke barrier door assemblies did not properly close and seal the opening, allowing the passage of smoke. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0374	Continued from page 7 Re-education provided for environmental services staff and Safety Committee to include proper closing and gasketing requirements for smoke barrier doors, Director of Environmental Services or their designee is responsible for monitoring of this plan of correction. Completion Date: 6/17/26	06/17/2026
K0541 SS = F Bldg. 01	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the chute door assembly(s) per	K0541	Facility has systems in place to ensure trash and laundry chutes are working properly per Life Safety regulations. Vendor was contacted on 06/11/2026 to replace, repair, and adjust laundry and rubbish chutes – in addition adding gaskets to better create a better air seal around doors. Parts to correct issue are on order. Once parts have been received by vendor, work will be scheduled. Waiver request is being submitted for work to be completed by 07/15/2026. Fusible link will be replaced on 6/12/2026. Education will be provided for Maintenance staff including inspections of trash and laundry chutes to ensure proper closure, chutes must be fully closed when not in use, inspection notes and any noted issues will be forwarded to Director of Environmental services for follow up. Safety Committee will be responsible for monitoring of this plan and any noted issues will be discussed at Safety Committee meetings. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction. Completion Date: 06/17/2026	06/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245233	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **05/19/2026**

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K0541 SS = F Bldg. 01	Continued from page 8 NFPA 101 (2012 edition), section 19.5.4.4, 9.5, and NFPA 82 (2009 edition), section 5.2.3.1, 5.2.3.2, 5.2.3.3, 10.2.2.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 05/19/2026 between 9:30 AM to 3:00 PM, it was revealed by observation and testing that the laundry and garbage chute door(s) located on the 5th thru 2nd Floor(s) did not function properly upon test to close and seal the vertical shaft(s). On 05/19/2026 between 2:00 PM, it was revealed by observation that the laundry chute door located on Ground / Basement of the facility had a damaged / non-functional fusible link. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0541		06/17/2026
K0914 SS = F Bldg. 01	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by:	K0914	Facility has systems in place to ensure electrical outlet testing is completed per NFPA 99 regulations. Electrical outlet testing has commenced and will be finished by compliance date. Electrical outlet testing has been included in TELS (our preventative maintenance program) with document tracking. Results of electrical outlet inspections will be provided to Director of Environmental Services for review and signature. Any issues will be immediately addressed and brought forward to Safety Committee for discussion. Re-education provided for environmental services staff will include requirement of annual electrical outlet regulation. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction. Completion Date: 6/17/2026	06/17/2026

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K0914 SS = F Bldg. 01	Continued from page 9 Based on observation, a review of available documentation and staff interview, the facility failed to maintain and test electrical receptacle(s) in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.1.3, 6.3.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 05/19/2026 between 9:30 AM to 3:00 PM, it was revealed by review of available documentation that electrical outlet testing was last completed – 05/12/2025. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0914		06/17/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.	K0918	Facility has systems in place to ensure and maintain the on-site emergency generator system per NFPA 99. The testing of our generator was completed on 4/25/26. New batteries were ordered on 5/14/26 and install on 5/22/26. Documentation of the battery replacement has been uploaded into TELS, which will provide notification to the Director of Environmental Services or their designee when future battery replacements are due. Audit will be performed on annual basis to ensure compliance in all areas. Annual testing will continue to occur with document tracking. Top of Form Bottom of Form Education provided for all EVS related to the maintenance of emergency generator systems and where to locate preventative maintenance tasks in TELS. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction. Completion Date: 6/17/2026	06/17/2026

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K0918 SS = F Bldg. 01	Continued from page 10 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on observation, review of available documentation, and staff interview, the facility failed to maintain the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section, 5.6.4, 5.6.4.4, 5.6.4.5.1, 5.6.4.5.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/19/2026 between 9:30 AM to 3:00 PM, it was revealed by observation and review of available vendor documentation that the emergency generator batteries were installed – 04/2022. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0918		06/17/2026
K0293 SS = E Bldg. 01	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to properly maintain, test, and inspect exit signage per NFPA 101 (2012 edition), section(s) 19.2.10, 7.10, 7.10.1.8. These deficient findings could have a patterned impact on the residents within the facility.	K0293	Facility has systems in place to ensure exit signs are illuminated at all times. Exit signage on the 4th and 5th floors were replaced on 6/3/26. All additional exit signage was replaced on 06/10/2026. Exit sign illumination will be added to the safety checklist. Results of safety checklist inspections will be provided to Director of Environmental Services for review and signature. Any issues will be immediately addressed and brought forward to the Director of Environmental Services. Results of safety checklist will be brought forward to the safety committee for further discussion and input. Re-education provided for all staff include importance of immediately notifying Environmental Services of any non-functioning exit sign. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction.	06/17/2026

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K0293 SS = E Bldg. 01	Continued from page 11 Findings include: On 05/19/2026 between 10:00 AM to 10:30 AM, it was revealed by observation that the exit sign(s) located on the 5th and 4th FL of the facility were partially or non-illuminated. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0293	Continued from page 11 Completion Date: 6/17/26.	06/17/2026
K0353 SS = D Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.2.2, 5.2.1.1.2(5). This deficient finding could have an isolated impact on the residents within the facility. Findings include:	K0353	Facility has systems in place to ensure sprinkler heads are free of debris. The sprinkler heads in the kitchen and dish room were cleaned on 06/11/2026. A facility-wide inspection of sprinkler heads will be completed by 6/17/2026. Audit has been put in place for sprinkler head visual inspection to ensure they are debris free. Audits will occur every 6 months with an annual inspection completed by our vendor. Safety Committee will be involved in safety inspections. Results of safety checklist inspections will be provided to Director of Environmental Services for review and signature. Any issues will be immediately addressed and brought forward to Safety Committee for discussion. Re-education provided for Environmental Services staff on importance maintaining debris free sprinkler heads. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction. Completion Date: 6/17/2026	06/17/2026

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K0353 SS = D Bldg. 01	Continued from page 12 On 05/19/2025 at 1:00 PM, it was revealed by observation that sprinkler heads in the Kitchen / Dishwashing areas exhibited signs of debris loading. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0353		06/17/2026

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/19/2026. At the time of this survey, ST ANNE EXTENDED HEALTHCARE was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		06/17/2026

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 reverse for further 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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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. Address the measures that will be put in place to ensure the deficiency does not reoccur. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The actual or proposed date for completion of the remedy. ST ANNE EXTENDED HEALTHCARE a 6 story building with partial basement. The building was constructed 1962 and was determined to be of Type II (222) construction. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 99 beds and had a census of 89 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: = = =	K0000		06/17/2026

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K0000 Bldg. 01	Continued from page 2 SNF is separated by 2 hour rated fire wall from Assisted Living.	K0000		06/17/2026
K0222 SS = F Bldg. 01	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.	K0222	Facility has systems in place to ensure proper functioning of the controlling device of an egress door. The keypad for the 5th floor East stairwell door was repaired on 5/19/2026. All keypads were tested for proper functionality on 5/19/2026. Keypads for egress doors are included on the monthly EVS audit checklist. Results of audit checklist will be provided to the Director of Environmental Services for review and signature. Any issues will be immediately addressed. Re-education provided for all staff include importance of ensuring proper functioning of egress door controlling devices and reporting malfunctioning devices to EVS immediately. Re-education will also be discussed at Safety Committee. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction. Completion Date: 6/17/2026	06/17/2026

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K0222 SS = F Bldg. 01	Continued from page 3 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain functional operation of the controlling device of an egress door per NFPA 101 (2012 edition), Life Safety Code, section(s) 19.2.2.2.4, 7.2.1.6.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/19/2025 at 10:00 AM, it was revealed by observation that a 5th FL, stairwell exit door did not release upon test. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0222		06/17/2026
K0291 SS = F Bldg. 01	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and	K0291	Facility has systems in place to ensure emergency light testing is being completed monthly and documented. Per the attached documentation, all emergency light testing was completed during the fiscal year. Documentation related to testing results has been attached to this plan of correction. At the time of the survey, the documentation was not in facility's Fire Book, it was maintained in a separate binder. Emergency light testing will continue on a monthly	06/17/2026

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K0291 SS = F Bldg. 01	Continued from page 4 staff interview, the facility failed to maintain, test, and inspect the emergency lighting fixtures per NFPA 101 (2012 edition) Life Safety Code, sections 19.2.9.1, 7.9.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/19/2026 between 9:30 AM to 3:00 PM, it was revealed by a review of available documentation that no documentation was available to confirm emergency light testing is being completed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0291	Continued from page 4 basis. Results of testing will be brought to Safety Committee. Regulation was reviewed with Director of Environmental Services and education will be provided to all plant operations staff on where this separate binder is kept. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction. Completion Date: 6/17/2026	06/17/2026
K0324 SS = F Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain proper	K0324	Facility has systems in place to ensure and confirm that 6-month inspections of the Ansul type fire suppression system are being completed. Per the attached documentation, Ansul type fire suppression system was completed and facility is providing documentation of testing results. This was last completed on 1/28/26. At the time of the survey, the documentation had not been obtained from the vendor and placed in facility's Fire Book for Fire Marshal review. Director of Environmental Services or their designee will perform audits to review and track inspection reports on a quarterly basis. Regulation was reviewed with Director of Environmental Services and education will be provided to all plant operations staff on obtaining inspection reports and placing them in the Fire Book. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction. Completion Date: 6/17/2026	06/17/2026

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K0324 SS = F Bldg. 01	Continued from page 5 inspection and safety documentation in accordance with NFPA 101 (2012 edition), Life Safety Code, section(s) 9.2.3, 19.3.2.5.3, NFPA 96 (2014 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section(s) 4.1, 4.1.5, 11.2. This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 05/19/2026 between 9:30 AM to 3:00 PM, it was revealed by a review of available documentation that no documentation was available to confirm that 6-month inspections of the ansul type fire suppression system are being completed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0324		06/17/2026
K0363 SS = F Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are	K0363	Facility has systems in place to ensure corridor doors serving bariatric resident rooms are maintained per NFPA 101. Rooms 423,323, and 223 which are double door assembly serving bariatric resident rooms were equipped with proper latching hardware and gasketing to prevent the passage of smoke. Work was completed on 6/9/2026. Walk through of facility to inspect all resident room double doors to ensure proper latching and hardware and gasketing was completed on 5/19/2026. Education for Environmental Services staff will include requirement of appropriate gasketing on double doors to prevent passage of smoke. Inspection of all double doors to ensure proper gasketing serving bariatric rooms was added to safety checklist. Results of safety checklist inspections will be provided to Director of Environmental Services for review and signature. Any issues will be immediately addressed and brought forward to Safety Committee for discussion. Annual door inspection program will be added to safety checklists.	06/17/2026

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K0363 SS = F Bldg. 01	Continued from page 6 allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors serving bariatric resident rooms per NFPA 101 (2012 edition), Life Safety Code, section(s) 19.2.2.2.4, 7.2.1.6.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 05/19/2026 between 9:30 AM to 3:00 PM, it was revealed by observation that the following double door assembly serving bariatric resident rooms were not equipped with proper latching hardware and gasketing to prevent the passage of smoke - RML 423 / RML 323 / RML 232. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0363	Continued from page 6 Director of Environmental Services or their designee is responsible for monitoring of this plan of correction. Completion Date: 6/17/2026	06/17/2026
K0374 SS = F Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is NOT MET as evidenced by:	K0374	Facility has systems in place to ensure all smoke barrier doors close and seal properly. All smoke barrier doors on 2nd, 3rd, and 4th floor were inspected, new seals placed on doors and doors were adjusted on 06/01/2026. Annual testing will occur prior to September 19, 2026 per regulation. This task has been added to TELS preventative maintenance system. Smoke barrier doors are included on the safety audit checklist to ensure proper closing and sealing. Safety Committee will be involved in safety inspections. Results of safety checklist inspections will be provided to Director of Environmental Services for review and signature. Any issues will be immediately addressed and brought forward to Safety Committee for discussion.	06/17/2026

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K0374 SS = F Bldg. 01	Continued from page 7 Based on observation and staff interview, the facility failed to test, maintain, and inspect the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4 These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 05/19/2026 between 9:30 AM to 3:00 PM, it was revealed by observation that the 4th , 3rd, and 2nd Floor(s) - smoke barrier door assemblies did not properly close and seal the opening, allowing the passage of smoke. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0374	Continued from page 7 Re-education provided for environmental services staff and Safety Committee to include proper closing and gasketing requirements for smoke barrier doors, Director of Environmental Services or their designee is responsible for monitoring of this plan of correction. Completion Date: 6/17/26	06/17/2026
K0541 SS = F Bldg. 01	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the chute door assembly(s) per	K0541	Facility has systems in place to ensure trash and laundry chutes are working properly per Life Safety regulations. Vendor was contacted on 06/11/2026 to replace, repair, and adjust laundry and rubbish chutes – in addition adding gaskets to better create a better air seal around doors. Parts to correct issue are on order. Once parts have been received by vendor, work will be scheduled. Waiver request is being submitted for work to be completed by 07/15/2026. Fusible link will be replaced on 6/12/2026. Education will be provided for Maintenance staff including inspections of trash and laundry chutes to ensure proper closure, chutes must be fully closed when not in use, inspection notes and any noted issues will be forwarded to Director of Environmental services for follow up. Safety Committee will be responsible for monitoring of this plan and any noted issues will be discussed at Safety Committee meetings. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction. Completion Date: 06/17/2026	06/17/2026

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K0541 SS = F Bldg. 01	Continued from page 8 NFPA 101 (2012 edition), section 19.5.4.4, 9.5, and NFPA 82 (2009 edition), section 5.2.3.1, 5.2.3.2, 5.2.3.3, 10.2.2.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 05/19/2026 between 9:30 AM to 3:00 PM, it was revealed by observation and testing that the laundry and garbage chute door(s) located on the 5th thru 2nd Floor(s) did not function properly upon test to close and seal the vertical shaft(s). On 05/19/2026 between 2:00 PM, it was revealed by observation that the laundry chute door located on Ground / Basement of the facility had a damaged / non-functional fusible link. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0541		06/17/2026
K0914 SS = F Bldg. 01	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by:	K0914	Facility has systems in place to ensure electrical outlet testing is completed per NFPA 99 regulations. Electrical outlet testing has commenced and will be finished by compliance date. Electrical outlet testing has been included in TELS (our preventative maintenance program) with document tracking. Results of electrical outlet inspections will be provided to Director of Environmental Services for review and signature. Any issues will be immediately addressed and brought forward to Safety Committee for discussion. Re-education provided for environmental services staff will include requirement of annual electrical outlet regulation. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction. Completion Date: 6/17/2026	06/17/2026

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K0914 SS = F Bldg. 01	Continued from page 9 Based on observation, a review of available documentation and staff interview, the facility failed to maintain and test electrical receptacle(s) in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.1.3, 6.3.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 05/19/2026 between 9:30 AM to 3:00 PM, it was revealed by review of available documentation that electrical outlet testing was last completed – 05/12/2025. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0914		06/17/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.	K0918	Facility has systems in place to ensure and maintain the on-site emergency generator system per NFPA 99. The testing of our generator was completed on 4/25/26. New batteries were ordered on 5/14/26 and install on 5/22/26. Documentation of the battery replacement has been uploaded into TELS, which will provide notification to the Director of Environmental Services or their designee when future battery replacements are due. Audit will be performed on annual basis to ensure compliance in all areas. Annual testing will continue to occur with document tracking. Top of Form Bottom of Form Education provided for all EVS related to the maintenance of emergency generator systems and where to locate preventative maintenance tasks in TELS. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction. Completion Date: 6/17/2026	06/17/2026

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K0918 SS = F Bldg. 01	Continued from page 10 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on observation, review of available documentation, and staff interview, the facility failed to maintain the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section, 5.6.4, 5.6.4.4, 5.6.4.5.1, 5.6.4.5.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/19/2026 between 9:30 AM to 3:00 PM, it was revealed by observation and review of available vendor documentation that the emergency generator batteries were installed – 04/2022. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0918		06/17/2026
K0293 SS = E Bldg. 01	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to properly maintain, test, and inspect exit signage per NFPA 101 (2012 edition), section(s) 19.2.10, 7.10, 7.10.1.8. These deficient findings could have a patterned impact on the residents within the facility.	K0293	Facility has systems in place to ensure exit signs are illuminated at all times. Exit signage on the 4th and 5th floors were replaced on 6/3/26. All additional exit signage was replaced on 06/10/2026. Exit sign illumination will be added to the safety checklist. Results of safety checklist inspections will be provided to Director of Environmental Services for review and signature. Any issues will be immediately addressed and brought forward to the Director of Environmental Services. Results of safety checklist will be brought forward to the safety committee for further discussion and input. Re-education provided for all staff include importance of immediately notifying Environmental Services of any non-functioning exit sign. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction.	06/17/2026

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K0293 SS = E Bldg. 01	Continued from page 11 Findings include: On 05/19/2026 between 10:00 AM to 10:30 AM, it was revealed by observation that the exit sign(s) located on the 5th and 4th FL of the facility were partially or non-illuminated. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0293	Continued from page 11 Completion Date: 6/17/26.	06/17/2026
K0353 SS = D Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.2.2, 5.2.1.1.2(5). This deficient finding could have an isolated impact on the residents within the facility. Findings include:	K0353	Facility has systems in place to ensure sprinkler heads are free of debris. The sprinkler heads in the kitchen and dish room were cleaned on 06/11/2026. A facility-wide inspection of sprinkler heads will be completed by 6/17/2026. Audit has been put in place for sprinkler head visual inspection to ensure they are debris free. Audits will occur every 6 months with an annual inspection completed by our vendor. Safety Committee will be involved in safety inspections. Results of safety checklist inspections will be provided to Director of Environmental Services for review and signature. Any issues will be immediately addressed and brought forward to Safety Committee for discussion. Re-education provided for Environmental Services staff on importance maintaining debris free sprinkler heads. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction. Completion Date: 6/17/2026	06/17/2026

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(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
K0353 SS = D Bldg. 01	Continued from page 12 On 05/19/2025 at 1:00 PM, it was revealed by observation that sprinkler heads in the Kitchen / Dishwashing areas exhibited signs of debris loading. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0353		06/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245233	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/21/2026

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E0000	Initial Comments On 5/18/26-5/21/26 , a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		06/17/2026
F0000	INITIAL COMMENTS On 5/18/26-5/21/26, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 substantial compliance with the regulations has been attained.	F0000		06/17/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate	F0761	Facility has systems in place to ensure proper workflow is being followed when dating open medications. Facility has reviewed Medication storage and Labeling policy. R32 insulin pen was discarded and new pen was opened and dated for use. All facility residents with insulin pens were reviewed to ensure	06/17/2026

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 reverse for further 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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F0761 SS = D	Continued from page 1 accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: 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.	F0761	Continued from page 1 labeling of opened date. Re-education for licensed nurses and TMA's includes review of policy and ensuring open medications are dated properly per facility policy. Nurse Supervisor will be responsible for implementation of workflow. Audit to ensure compliance will include weekly medication cart and med fridge audit performed by Nurse Supervisor or their designee. 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. Completion Date: 6/17/2026	06/17/2026

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F0761 SS = D	Continued from page 2 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.	F0761		06/17/2026
F0790 SS = D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(f) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident;	F0790	Facility has systems in place to ensure proper workflow is being followed when completing care conference observation in Matrix, to ensure resident dental services were addressed. R9 routine dental visit in October and uploaded into resident documents. Facility will provide education for individuals who participate in resident care conferences on completion of care conference observation in Matrix. Meeting was held on 6/11/26. Social Services will be responsible for implementation of workflow. Audit to ensure compliance will include bi-weekly care conference observation completion audit performed by social services or their designee. 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 SNF Administrator or their designee is responsible for the monitoring of this plan of correction. Completion Date: 6/17/2026	06/17/2026

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F0790 SS = D	Continued from page 3 (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is NOT MET as evidenced by: 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 4/8/26 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	F0790		06/17/2026

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F0790 SS = D	Continued from page 4 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".	F0790		06/17/2026
F0791 SS = D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility-	F0791	Facility has systems in place to ensure proper workflow is being followed when completing care conference observation in Matrix, to ensure resident dental services were addressed. R29 routine dental visit in October and uploaded into resident documents. Facility will provide education for individuals who participate in resident care conferences on completion of care conference observation in Matrix. Meeting was held on 6/11/26. Social Services will be responsible for	06/17/2026

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F0791 SS = D	Continued from page 5 §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is NOT MET as evidenced by: 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 3/14/26 identified R29 with significantly impaired cognition,	F0791	Continued from page 5 implementation of workflow. Audit to ensure compliance will include bi-weekly care conference observation completion audit performed by social services or their designee. 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 SNF Administrator or their designee is responsible for the monitoring of this plan of correction. Completion Date: 6/17/2026	06/17/2026

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F0791 SS = D	Continued from page 6 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	F0791		06/17/2026

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F0791 SS = D	Continued from page 7 services are provided to our residents" and "All dental services provided are recorded in the resident's medical record".	F0791		06/17/2026
F0812 SS = D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: 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 tatar tot and a taco wrapped in brown paper from taco john, 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	F0812	Facility has systems in place to ensure proper workflow is being followed when labeling and storing of food on resident units. Facility has reviewed Food storing and labeling policies for accuracy. All shared resident refrigerators were reviewed to ensure the proper labeling and dating of contents. Re-education for all nursing and culinary staff will include review food storage and labeling. Audit to ensure compliance will occur weekly for 6 weeks and include spot checking to ensure open food products are dated correctly. SNF Administrator or their designee will be responsible for implementation of workflow. 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 SNF Administrator or their designee is responsible for the monitoring of this plan of correction. Completion Date: 06/17/2026	06/17/2026

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F0812 SS = D	Continued from page 8 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, tatar tot and a taco from Taco John 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.	F0812		06/17/2026

Minnesota Department of Health

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20000	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 5/18/26-5/21/26, a standard licensing 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 Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal	20000		06/17/2026

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

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20000	Continued from page 1 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 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 heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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.	20000		06/17/2026
21325	Providing Routine & Emergency Oral Health Ser CFR(s): MN Rule 4658.0725 Subp. 1 Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This LICENSURE REQUIREMENT is NOT MET as	21325		06/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/21/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Anne Extended Healthcare	**1347 WEST BROADWAY STREET , WINONA, Minnesota, 55987**

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21325	Continued from page 2 evidenced by: 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, R29) reviewed for dental hygiene and services. Findings include: R9's annual Minimum Data Set dated 4/8/26 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	21325		06/17/2026

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21325	Continued from page 3 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." R29 R29’s quarterly Minimum Data Set dated 3/14/26 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	21325		06/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/21/2026**

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21325	Continued from page 4 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”. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures related to dental agreements and educate staff on these requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21325		06/17/2026
21426	Tuberculosis Prevention And Control CFR(s): MN St. Statute 144A.04 Subd. 3 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the	21426		06/17/2026

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21426	Continued from page 5 guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on document review and record review, the facility failed to complete tuberculosis (TB) symptom screening for 2 of 5 (R19, R64) residents reviewed. Findings include: R64's medical record identified R64 was admitted 4/13/26 however did not have a TB baseline symptom screening completed. R19's medical record identified R19 was admitted 4/10/26 however did not have a TB baseline symptom screening completed. During a joint interview on 5/19/26 at 5:22 p.m., the Regional Director of Clinical Services (RC-C) and director of nursing (DON) confirmed they were unable to find a TB symptom screening for R64 and R19. The DON stated the infection preventionist (IP) is responsible for making sure the TB screening and testing is completed. The DON stated the symptom screenings were signed off on the medication administration record, however confirmed they were not completed. During an interview on 5/19/26 at 8:36 a.m., the IP stated all residents are given a first step TB test the evening of their admission date. The second step is automatically scheduled 2 weeks later. The TB symptom screening is documented under the observation tab in the electronic medical record. The IP confirmed she is responsible for ensuring symptoms screening and TB testing is completed for newly admitted residents. A policy titled Tuberculosis screening of Residents, dated 8/2023 indicated "It is the policy of [the facility] to provide Tuberculosis screening on new and returning residents per State and Federal recommendations." The procedure of baseline TB screening is defined as assessing for current symptoms of active TB disease, assessing for TB risk factors and TB history, and testing for the presence of infection through two-step tuberculin skin testing. SUGGESTED METHOD OF CORRECTION: The	21426		06/17/2026

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21426	Continued from page 6 infection preventionist, director of nursing (DON) and/or designee should review policies and procedures related to the screening and testing for tuberculosis for residents. Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions as well as current residents to ensure compliance. The IP, DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty one- (21) days	21426		06/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245233	A. BUILDING **01 - MAIN BUILD...** B. WING	**06/22/2026**

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K0000 Bldg. 01	INITIAL COMMENTS Based on an on-site revisit, the facility is NOT in compliance with the Federal requirements identified as deficient at the time of their recertification survey.	K0000		07/15/2026
K0914 SS = F Bldg. 01	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on an on-site revisit, the facility is NOT in compliance with the Federal requirements identified as deficient at the time of their recertification survey.	K0914		
K0353 SS = D Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with	K0353		

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245233	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **06/22/2026**

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K0353 SS = D Bldg. 01	Continued from page 1 NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on an on-site revisit, the facility is NOT in compliance with the Federal requirements identified as deficient at the time of their recertification survey.	K0353		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 15, 2026

Administrator
Saint Anne Extended Healthcare
1347 WEST BROADWAY STREET
WINONA, MN 55987

RE: CCN: 245233

Cycle Start Date: May 21, 2026

Dear Administrator:

On June 4, 2026, we informed you that we may impose enforcement remedies.

On July 7, 2026, the Minnesota Department of Health and Public Safety completed revisits, and it has been determined that your facility is not in substantial compliance.

The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiencyies not corrected is/are as follows:

- K0353: Sprinkler System - Maintenance and Testing
- K0914: Electrical Systems - Maintenance and Testing Standard

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:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 21, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 21, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 21, 2026.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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 $13,343, 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.

If you have not achieved substantial compliance by August 21, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Saint Anne Extended Healthcare will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 21, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for

new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies **(those preceded by a "K" tag)** i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

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:

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 21, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security

Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

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:

tamika.brown@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 tamika.brown@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

Office: 651-201-4384
Email: holly.zahler@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/21/2026**

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Saint Anne Extended Healthcare	**1347 WEST BROADWAY STREET , WINONA, Minnesota, 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
20000	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 5/18/26-5/21/26, a standard licensing 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 Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal	20000		06/17/2026

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

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20000	Continued from page 1 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 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 heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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.	20000		06/17/2026
21325	Providing Routine & Emergency Oral Health Ser CFR(s): MN Rule 4658.0725 Subp. 1 Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This LICENSURE REQUIREMENT is NOT MET as	21325		06/17/2026

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21325	Continued from page 2 evidenced by: 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, R29) reviewed for dental hygiene and services. Findings include: R9's annual Minimum Data Set dated 4/8/26 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	21325		06/17/2026

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21325	Continued from page 3 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." R29 R29’s quarterly Minimum Data Set dated 3/14/26 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	21325		06/17/2026

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21325	Continued from page 4 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”. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures related to dental agreements and educate staff on these requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21325		06/17/2026
21426	Tuberculosis Prevention And Control CFR(s): MN St. Statute 144A.04 Subd. 3 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the	21426		06/17/2026

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21426	Continued from page 5 guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on document review and record review, the facility failed to complete tuberculosis (TB) symptom screening for 2 of 5 (R19, R64) residents reviewed. Findings include: R64's medical record identified R64 was admitted 4/13/26 however did not have a TB baseline symptom screening completed. R19's medical record identified R19 was admitted 4/10/26 however did not have a TB baseline symptom screening completed. During a joint interview on 5/19/26 at 5:22 p.m., the Regional Director of Clinical Services (RC-C) and director of nursing (DON) confirmed they were unable to find a TB symptom screening for R64 and R19. The DON stated the infection preventionist (IP) is responsible for making sure the TB screening and testing is completed. The DON stated the symptom screenings were signed off on the medication administration record, however confirmed they were not completed. During an interview on 5/19/26 at 8:36 a.m., the IP stated all residents are given a first step TB test the evening of their admission date. The second step is automatically scheduled 2 weeks later. The TB symptom screening is documented under the observation tab in the electronic medical record. The IP confirmed she is responsible for ensuring symptoms screening and TB testing is completed for newly admitted residents. A policy titled Tuberculosis screening of Residents, dated 8/2023 indicated "It is the policy of [the facility] to provide Tuberculosis screening on new and returning residents per State and Federal recommendations." The procedure of baseline TB screening is defined as assessing for current symptoms of active TB disease, assessing for TB risk factors and TB history, and testing for the presence of infection through two-step tuberculin skin testing. SUGGESTED METHOD OF CORRECTION: The	21426		06/17/2026

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21426	Continued from page 6 infection preventionist, director of nursing (DON) and/or designee should review policies and procedures related to the screening and testing for tuberculosis for residents. Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions as well as current residents to ensure compliance. The IP, DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty one- (21) days	21426		06/17/2026

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E0000	Initial Comments On 5/18/26-5/21/26 , a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		06/17/2026
F0000	INITIAL COMMENTS On 5/18/26-5/21/26, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 substantial compliance with the regulations has been attained.	F0000		06/17/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate	F0761	Facility has systems in place to ensure proper workflow is being followed when dating open medications. Facility has reviewed Medication storage and Labeling policy. R32 insulin pen was discarded and new pen was opened and dated for use. All facility residents with insulin pens were reviewed to ensure	06/17/2026

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 reverse for further 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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F0761 SS = D	Continued from page 1 accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: 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.	F0761	Continued from page 1 labeling of opened date. Re-education for licensed nurses and TMA's includes review of policy and ensuring open medications are dated properly per facility policy. Nurse Supervisor will be responsible for implementation of workflow. Audit to ensure compliance will include weekly medication cart and med fridge audit performed by Nurse Supervisor or their designee. 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. Completion Date: 6/17/2026	06/17/2026

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F0761 SS = D	Continued from page 2 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.	F0761		06/17/2026
F0790 SS = D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(f) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident;	F0790	Facility has systems in place to ensure proper workflow is being followed when completing care conference observation in Matrix, to ensure resident dental services were addressed. R9 routine dental visit in October and uploaded into resident documents. Facility will provide education for individuals who participate in resident care conferences on completion of care conference observation in Matrix. Meeting was held on 6/11/26. Social Services will be responsible for implementation of workflow. Audit to ensure compliance will include bi-weekly care conference observation completion audit performed by social services or their designee. 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 SNF Administrator or their designee is responsible for the monitoring of this plan of correction. Completion Date: 6/17/2026	06/17/2026

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F0790 SS = D	Continued from page 3 (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is NOT MET as evidenced by: 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 4/8/26 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	F0790		06/17/2026

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F0790 SS = D	Continued from page 4 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".	F0790		06/17/2026
F0791 SS = D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility-	F0791	Facility has systems in place to ensure proper workflow is being followed when completing care conference observation in Matrix, to ensure resident dental services were addressed. R29 routine dental visit in October and uploaded into resident documents. Facility will provide education for individuals who participate in resident care conferences on completion of care conference observation in Matrix. Meeting was held on 6/11/26. Social Services will be responsible for	06/17/2026

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F0791 SS = D	Continued from page 5 §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is NOT MET as evidenced by: 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 3/14/26 identified R29 with significantly impaired cognition,	F0791	Continued from page 5 implementation of workflow. Audit to ensure compliance will include bi-weekly care conference observation completion audit performed by social services or their designee. 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 SNF Administrator or their designee is responsible for the monitoring of this plan of correction. Completion Date: 6/17/2026	06/17/2026

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F0791 SS = D	Continued from page 6 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	F0791		06/17/2026

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F0791 SS = D	Continued from page 7 services are provided to our residents" and "All dental services provided are recorded in the resident's medical record".	F0791		06/17/2026
F0812 SS = D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: 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 tatar tot and a taco wrapped in brown paper from taco john, 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	F0812	Facility has systems in place to ensure proper workflow is being followed when labeling and storing of food on resident units. Facility has reviewed Food storing and labeling policies for accuracy. All shared resident refrigerators were reviewed to ensure the proper labeling and dating of contents. Re-education for all nursing and culinary staff will include review food storage and labeling. Audit to ensure compliance will occur weekly for 6 weeks and include spot checking to ensure open food products are dated correctly. SNF Administrator or their designee will be responsible for implementation of workflow. 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 SNF Administrator or their designee is responsible for the monitoring of this plan of correction. Completion Date: 06/17/2026	06/17/2026

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F0812 SS = D	Continued from page 8 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, tatar tot and a taco from Taco John 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.	F0812		06/17/2026