Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 2, 2022

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

RE: CCN: 245233
Cycle Start Date: May 26, 2022

Dear Administrator:

On July 26, 2022, the Minnesota Department of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
August 2, 2022

CMS Certification Number (CCN): 245233

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.
Effective July 7, 2022 the above facility is certified for:

109 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 109 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Electronically delivered
June 15, 2022

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

RE: CCN: 245233
Cycle Start Date: May 26, 2022

Dear Administrator:

On May 26, 2022, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 26, 2022 (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 26, 2022 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245233	A. BUILDING ______ B. WING ______	C 05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE EXTENDED HEALTHCARE	**1347 WEST BROADWAY STREET WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Minnesota Department of Health (MDH) on 05/23/22 through 05/26/22. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted on 5/23/22 - 5/26/22 by Healthcare Management Solutions, LLC on behalf of the Minnesota Department of Health (MDH). The facility was found to be in substantial compliance with 42 CFR 483 subpart B. No deficiencies were issued related to Intakes: MN00075957 H5233047C MN00077558 H5233048C MN00083621 H52331803C MN00083661 H52331806C	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 06/15/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245233	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/25/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE EXTENDED HEALTHCARE	**1347 WEST BROADWAY STREET** **WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

An annual life safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/25/2022. At the time of this survey, SAINT ANNE EXTENDED CARE 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/24/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245233	A. BUILDING **01 - MAIN BUILDING 01** B. WING ____	**05/25/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE EXTENDED HEALTHCARE	**1347 WEST BROADWAY STREET** **WINONA, MN 55987**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 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: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. SAINT ANNE EXTENDED CARE is 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.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245233	A. BUILDING **01 - MAIN BUILDING 01** B. WING ____	**05/25/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE EXTENDED HEALTHCARE	**1347 WEST BROADWAY STREET** **WINONA, MN 55987**

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K 000	Continued From page 2 The facility has a capacity of 109 beds and had a census of 79 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to inspect and maintain initiating devices of fire alarm system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.4, and 9.6.1.7(3), and NFPA 72 (2010 edition) National Fire Alarm and Signal Code, sections 14.1.1 and 14.2.1.2, 14.2.2 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/25/2022 between 10:00 AM to 03:00 PM, it was revealed during documentation review that the fire alarm system servicing vendor had noted malfunctions found in the course of servicing the system - doors that were supposed to release on	K 345	Facility has systems in place to ensure proper testing, maintenance and follow up on the fire alarm system. Report dated 8/10/2021 from Custom Alarm stated During fire inspection the following deficiency was found. 1) The doors that are supposed to unlock when system is in alarm, did not unlock. EVS Director reached out to Custom Alarm and report submitted to Fire Marshall on 6/17/22 stating the following: Notes regarding deficiency Found it was all wander guard doors after making some calls. Looked at doors with customer. Looked in programming and they are programmed correctly. Found that inspectors did not trip a specific	7/7/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245233	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/25/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE EXTENDED HEALTHCARE	**1347 WEST BROADWAY STREET** **WINONA, MN 55987**

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K 345	Continued From page 3 fire alarm did not release. No supporting documentation was provided or available for review to confirm the noted malfunction had been repaired An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	device on the same floor as the doors associated with it. I let them know and put a note in the system so they remember how to do it next year. No charge. Director of Environmental Services will review all reports from outside vendors to ensure appropriate documentation was received. Completed and documented follow up will be put into the Life Safety binder. Education will be provided to all maintenance staff regarding outside vendors and the need to report noted follow up to the Director of Environmental Services. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction.	
K 353 SS=E	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 ______	K 353		7/7/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245233	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/25/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE EXTENDED HEALTHCARE	**1347 WEST BROADWAY STREET** **WINONA, MN 55987**

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K 353	Continued From page 4 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 REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.6, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1, 5.2, and 5.2.2.2, NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 8.5.6, and 8.5.6.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 05/25/2022 between 10:00 AM to 03:00 PM, it was revealed by observation that items were placed closer than eighteen inches to the sprinkler head(s) in the following locations: RM 24 and the Physical Therapy storage closet 2. On 05/25/2022 between 10:00 AM to 03:00 PM, it was revealed by observation in the areas that sprinkler heads were exhibiting signs of oxidation: 5th FL Wet Closet and Kitchen Dishwashing area 3. On 05/25/2022 between 10:00 AM to 03:00 PM, it was revealed be observation that the sprinkler head located in the hallway alcove	K 353	Facility has systems in place to ensure no high storage in sprinkled closets and sprinkler heads are properly maintained. By 6/30/22 high storage will be removed from the office 24 and the OT closet and the closets marked for high storage limit. On 6/22/22 oxidized sprinkler heads were replaced in 5th floor housekeeping closet, the kitchen dishwashing room and in the volunteer nook. Maintenance checklist has been developed to inspect all sprinkler heads twice a year, around the annual inspection from outside vendor of the sprinkler company. Maintenance audit checklist has been updated to monitor high storage on a weekly basis. Education will be provided to all staff related to risk of high storage impeding on sprinkler system. In addition, education will be provided to all maintenance staff related to maintenance of sprinkler heads and the newly developed checklist. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245233	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/25/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE EXTENDED HEALTHCARE	**1347 WEST BROADWAY STREET** **WINONA, MN 55987**

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K 353	Continued From page 5 adjacent to RM105 was missing an escutcheon cover and was covered in white paint An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353		
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain, test, and inspect the facility smoke dampers system per NFPA 101 (2012 edition), Life Safety Code, sections 8.5, 8.5.5.2, 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2 This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 372	Facility has systems in place to ensure smoke damper system is regularly inspected and maintained. On 6/16/22 the inspection of the smoke damper system was completed. A task was entered into our TELS preventative maintenance system to ensure the smoke damper inspection is complete per required schedule. Education will be provided to all	7/7/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245233	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/25/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANNE EXTENDED HEALTHCARE	**1347 WEST BROADWAY STREET** **WINONA, MN 55987**

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K 372	Continued From page 6 On 05/25/2022 between 10:00 AM to 03:00 PM, it was revealed by a review of available documentation that no documentation was available or presented for review to confirm that fire / smoke damper inspection and testing is being completed. Last documented testing was completed on 12/17/2017. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 372	maintenance staff related to the reviewing and monitoring the TELS regulatory tasks that need to be completed on a regular basis. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction.	
K 541 SS=F	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	K 541		7/7/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245233	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/25/2022**

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SAINT ANNE EXTENDED HEALTHCARE	**1347 WEST BROADWAY STREET** **WINONA, MN 55987**

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K 541	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain and secure the laundry chute system per NFPA 101 (2012 edition), Life Safety Code, section 19.5.4, 9.5, 8.4, and NFPA 82 (2009 edition), Standard on Incinerators and Waste and Linen Handling Systems and Equipment, sections 5.2, 5.2.3.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/25/2022 between 10:00 AM to 03:00 PM, it was revealed by observation that the laundry chute discharge was absent of a protective automatic or self-closing door. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 541	Facility has systems in place to ensure the laundry chute discharge is secured. Facility has reached out to order new fire code door which will be installed at a later date when company has finished manufacturing the door. Facility has arranged for a temporary door to be installed on the chute until the permanent door is ready for installation. Maintenance safety checklist was updated to include audits of this door being secured. Education will be provided to environmental services staff on the requirement that this door be closed after emptying chute. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction.	
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded	K 712		7/7/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	245233	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/25/2022**

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K 712	Continued From page 8 announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1, and 4.7 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/25/2022 between 10:00 AM to 03:00 PM, it was revealed by a review of available documentation that no fire drill was conducted on 2nd shift in the 4th quarter, and the 3rd shift in the 1st quarter. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	Facility policy related to conducting fire drills was reviewed and updated. Facility will utilize a tracking tool to ensure fire drills are held at least quarterly on each shift. Fire drills and results will be documented and included in facility Life Safety Code binder. Maintenance will provide nursing with an instruction sheet including specific time frame that a drill needs to be completed for certain shifts outside of normal maintenance hours. Re-education related to appropriate steps for fire drill documentation is being provided for maintenance staff and nursing staff responsible for conducting fire drills. Director of Environmental Services will review each fire drill report to ensure they are filled out completely and reflect all required documentation. Director of Environmental Services will forward a copy of each report to Assistant Executive Director for additional review. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101	K 920		7/7/22

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K 920	Continued From page 9 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly manage the implementation and usage of electrical adaptive devices in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 400-8, 590.3(D), and UL1363. This deficient finding could have a patterned impact on the residents within the facility. Findings include:	K 920	Facility has systems in place to ensure appliances are not plugged into power strips and there are no daisy chained power strips. On 6/17/22 office 522 and office 101 daisy chained power strips were removed. In rooms 402, 307, and in the beauty shop the A/C units were plugged directly into wall outlets on 6/17/22 as well. Maintenance safety checklist was updated	

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K 920	Continued From page 10 1. On 05/25/2022 between 10:00 AM to 03:00 PM, it was revealed by observation that in RM 522 and RM 101 that daisy-chained power-strips were in use 2. On 05/25/2022 between 10:00 AM to 03:00 PM, it was revealed by observation that in RM 402, RM 307, and the Beauty Shop that a window air conditioner was connected to a power-strip An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	to monitor for and address possible issues with power adapters. Education will be provided for all staff on the improper use of power adapters and daisy chained power strips. Education will also be provided to all on plugging appliances directly into the wall outlet. Education will be provided to maintenance staff on the updated checklist. Director of Environmental Services or their designee is responsible for monitoring of this plan of correction.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be	K 923		7/7/22

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K 923	Continued From page 11 handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2, 11.3.4, 11.6.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/25/2022 between 10:00 AM to 03:00 PM, it was revealed by observation in RM 524A Med Gas Storage Room that there was no signage to identify the separation of empty and full cylinders An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	Facility has systems in place to ensure appropriate storage of gas cylinders and containers. On 6/17/22, oxygen containers were moved to appropriate side of storage closet on 5th floor to ensure defined separation. Fifth floor unit storage room has been set up to include a visible barrier between empty and full canisters. Clear signage to indicate where empty and full containers should be stored has been posted. An audit checklist has been updated to ensure oxygen room cylinders are correctly separated. Re-education will be provided for nursing and maintenance staff related to appropriate storage of oxygen containers.	

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K 923	Continued From page 12	K 923	Director of Environmental Services or their designee is responsible for monitoring of this plan of correction.	