Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 30, 2026

Administrator
St. Crispin Living Community
213 Pioneer Road
Red Wing, MN 55066

RE: CCN: 245449
Cycle Start Date: **March 2, 2026**

Dear Administrator:

On March 12, 2026, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 27, 2026.

On March 19, 2026, the Minnesota Department(s) of Health and Public Safety completed a standard recertification survey and it has been determined that your facility continues to not to be 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 deficiencies not corrected are as follows:

F609, F697, F710, and F755

In addition, at the time of this survey, we identified the following deficiencies:

F881, F842, F605, F677, F812,
K920, K712 (bldg 1), K712 (bldg 2), K374, K355, K345 (bldg 1), K345 (bldg 2)

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 27, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 27, 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.

As we notified you in our letter of [First State Notice Date()], in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 27, 2026.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

Questions 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 September 2, 2026 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

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 Tamika Brown at (312) 353-1502. 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.

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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD , RED WING, Minnesota, 55066

(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
E0000	Initial Comments On 3/17/26 to 3/19/26, 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		
F0000	INITIAL COMMENTS On 3/17/19 to 3/19/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54499060C (2807348). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity.	F0605		

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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F0605 SS = D	Continued from page 1 The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic.	F0605		

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F0605 SS = D	Continued from page 2 §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.	F0605		

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F0605 SS = D	Continued from page 3 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to complete medication side effect monitoring for 1 of 5 residents (R49) reviewed for unnecessary medications who received antipsychotics. Findings include: R49's quarterly Minimum Data Set (MDS) assessment dated 12/16/25 indicated R49 had moderate cognitive impairment with no behaviors. R49 required substantial/maximal assistance with personal hygiene, showering/bathing, and upper body dressing. R49 was dependent on facility staff for lower body dressing, position transfers, and toileting. R49's care plan dated 3/13/2025, titled "Psychotropic Drug Use-I have a DX: Depression et receive psychotropic medication as ordered" indicated: R49 will not experience any adverse reactions through the review date. R49's care plan lacked guidelines for orthostatic blood pressure monitoring; a potential side effect of psychotropic medications. R49's Medication Administration Record (MAR) indicated the following: -Give Risperdal (an antipsychotic medication used to treat psychiatric symptoms) 0.5 mg once in the evening. R49's orders lacked orthostatic blood pressure monitoring. R49's vital signs record lacked orthostatic blood pressure readings. R49's progress notes lacked documentation orthostatic blood pressures were attempted or any refusals. During an interview on 3/18/26 at 12:33 p.m., licensed	F0605		

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F0605 SS = D	Continued from page 4 practical nurse (LPN)-A stated not many residents have orders for orthostatic blood pressure monitoring. LPN-A stated orthostatic blood pressure monitoring would be a provider order or a task populated from the care plan. LPN-A stated R49 did not have a provider order or care planned task for orthostatic blood pressure monitoring. LPN-A was unsure why someone on antipsychotic medication would need orthostatic blood pressure monitoring. During an interview on 3/19/26 at 9:32 a.m., Regional Director of Clinical Services (RCS) and Registered Nurse (RN)-A stated when a resident is started on an antipsychotic, such as Risperdal, the facility has a protocol they implement to ensure side effect and symptom monitoring is completed. RCS stated side effect monitoring included orthostatic blood pressure monitoring. RCS and RN-A confirmed orthostatic blood pressure monitoring orders and care planned tasks were not completed for R49. RCS stated orthostatic blood pressure monitoring is important for residents taking antipsychotic medications because low blood pressure can be a side effect of the medications. A facility policy for psychotropic medication monitoring was asked for and was not received.	F0605		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to provide for activities of daily living (ADL) for 2 of 2 residents (R1, R3) who were dependent on staff for timely incontinence care and eating assistance (R1) and assistance for personal hygiene (R3). Findings include: R1: R1's significant change Minimum Data Set (MDS) dated 2/9/26, indicated R1 had severe cognitive impairment with no behaviors. R1 required substantial assist with	F0677		

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F0677 SS = D	Continued from page 5 eating, was dependent on staff for all other ADLs, received a mechanically altered diet, and received hospice care. R1 also had a stage 3 pressure injury. R1's diagnoses list, undated, included dementia, kidney disease, anemia, and left heel pressure injury. R1's provider orders included hospice care due to late onset Alzheimer's (a disorder causing progressive decrease in cognition), "provide oversight/intake assistance at mealtimes and as needed", and treatment orders to a pressure injury to left heel. R1's care plan last reviewed 2/10/26, indicated incontinent of bladder and bowel and "check and change every 2-3 hours and as needed', "reposition every 2-3 hours" and "provide assistance with eating, per nursing determination" and left heel pressure injury. R1's progress notes dated 3/13/26, indicated "Resident fed by staff food and fluids this shift. Ate 100% of meal. Resident could not feed self, due to continued weakness." During semi-continuous observation on 3/18/26 the following was observed: -9:29 a.m., R1 was seated in the wheelchair in the common area -10:15 a.m., an unidentified staff member took R1 to church service. -11:39 a.m., an activities aide brought R1 back from church to the dining room for lunch. -12:04 p.m., a staff member brough R1 her lunch of a peanut butter and jelly sandwich, mashed potatoes, and cooked carrots. The staff member handed half the sandwich to R1. R1 ate the half sandwich however made no attempt to eat the rest of the food on her plate. No staff present to assist or encourage R1 to eat. -12:15 p.m., nursing assistant (NA)-B handed R1 the other half sandwich and offered her a drink. R1 ate the half sandwich while NA-B assisted tablemates. When the tablemates declined assistance, NA-B walked away. R1 finished the half sandwich and made no further attempt to eat. -12:21 pm., a staff member was observed sitting at a table on the other side of the dining room assisting another resident. A nurse arrived a R1's table and assisted a tablemate to eat. The nurse spoke to R1	F0677		

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F0677 SS = D	Continued from page 6 however did not offer to assist with feeding. -12:33 p.m., R1 remained at the table. No attempts made to eat or drink. No staff present to assist. -12:47 p.m., R1 remained at the table with the remainder of her food untouched. Incontinence care/eating assistance During an interview on 3/18/26 at 12:49 p.m., nursing assistant (NA)-A stated R1 is dependent on staff for all activities of daily living and is provided incontinence care every 2-3 hours. NA-A stated R1 was provided incontinence care at around 10:00 a.m., however then stated she was not aware R1 was taken to church. NA-A then stated, "I have to lay her down now and change her." NA-A stated R1 will hold and eat sandwiches however requires staff assistance with other foods. R1 doesn't each much but will if someone helps her. NA-A confirmed she did not assist R1 with eating at lunch. During observation at 12:55 p.m., (3 hours and 26 minutes after the first observation) R1 was taken back to her room and transferred into bed. R1 had been incontinent of urine and the back of R1's thighs had reddened indentations resembling the shape of the waffle pressure relieving cushion on her wheelchair. During interview on 3/18/26 at 3:19 a.m., licensed practical nurse (LPN)-A stated R1 has advanced dementia and requires assistance for all ADLs. LPN-A stated R1 sits at the assisted table and will "sometimes" feed herself. One nursing assistant is assigned to monitor the dining room however they will occasionally "get pulled out" [of the dining room]. Eating assistance During an interview on 3/19/26 at 9:08 a.m., registered nurse (RN)-B confirmed R1 is under hospice care. RN-B stated R1 required full assistance with eating. R1 will stare at food in front of her and make no attempt to feed self. RN-B stated, "even if I hand her finger food, she will put it down." RN-B stated she tries to schedule visits during mealtimes to assist R1 with eating. There are days R1 does not eat much however will normally eat 100% when RN-B assists her. During an interview on 3/19/26 at 9:25 a.m., the registered dietician (RD) confirmed R1 is under hospice care and nutrition is provided for comfort. The RD confirmed R1 has a pressure injury and continues to be	F0677		

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F0677 SS = D	Continued from page 7 followed while under hospice care. The RD stated it is "common sense" nutrients are needed for wounds to heal and not get worse. The nursing department determines the type of assistance a resident requires for eating. Eating assistance/Incontinence care During an interview on 3/19/26 at 10:37 a.m., the Regional Director of Clinical Services stated it is expected all dependent residents are repositioned and provided incontinence care every 2-3 hours. It is also expected staff assist dependent residents with eating to promote wound healing. A policy titled "Activities of Daily Living" dated 2021 indicated residents unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming, personal hygiene, elimination, communication and mobility. Care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care), elimination (toileting) and dining (meals and snacks). R3: R3's quarterly Minimum Data Set (MDS) dated 3/11/26 indicated R3 was cognitively intact with some refusals of care from specific staff. R3 is dependent on staff for personal hygiene, toileting hygiene, and lower body dressing. R3 requires substantial/maximal assistance for oral hygiene, shower/bathing, and upper body dressing. R3's diagnosis includes Alzheimer's disease (progressive, incurable neurological disorder that causes brain cells to die), peripheral neuropathy (damage to the peripheral nerves, often causing numbness, tingling, weakness, in hands and feet), major depressive disorder, and generalized weakness. R3's provider orders included bath day Thursday PM: obtain weight, vitals, and observe for new skin issues. Include grooming performed, shaving, nail care etc. Document refusals and approaches used. R3's treatment administration record (TAR) indicated R3 received a bath on 3/5/26 at 7:34 p.m., "Bath completed, redness under right breast noted, Linens changed. VSS done and recorded. Resident had all snack between meals 100%, pleasant and cooperative with cares". Additionally, R3 received a bath on 3/12/26 at 11:40 p.m., "Resident	F0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245449**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/19/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	**213 PIONEER ROAD , RED WING, Minnesota, 55066**

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F0677 SS = D	Continued from page 8 received a scheduled tub bath, no c/o pain or discomfort, no skin issues noted. Vital signs are intact”. R3’s care plan dated 1/26/26, titled “I have a self-deficit with the following activities of daily living, bathing, grooming, oral cares, ambulation, transferring, mobility, vision, bowel and bladder” indicated: R3 will participate as able. R3’s interventions for self-deficit included asking for assistance, require assistance of 2 for toileting needs, and assist of 1 with dressing/undressing, grooming, and hygiene. During an observation on 3/17/26 at 5:44 p.m., R3 had multiple long hairs on her upper lip and multiple long hairs on her chin. During an observation and interview on 3/18/26 at 10:06 a.m., R3 stated she does not like the hairs on her face (upper lip and chin), stated she had told staff that she wanted them removed but no one has helped her. R3 stated she wonders why they don't do it on bath days, that would be the easiest. During an interview on 3/18/26 at 12:29 p.m., nursing assistant (NA)-C confirmed R3 had several long hairs on both her upper lip and chin. NA-C stated facial hair removal or shaving occurred on bath days. NA-C stated R3 is very particular about who provides her care; R3 will complete tasks without issue if she trusts you. NA-C confirmed R3 had not refused bathing/grooming assistance in the last month. During an interview on 3/18/26 at 12:33 p.m., licensed practical nurse (LPN)-A stated R3 will refuse cares if she doesn’t know or trust you. LPN-A stated when a nursing assistant tells her the resident is refusing something, LPN-A will make sure to ask a trusted nursing assistant to complete the task. LPN-A confirms hair removal and grooming typically occurs on bath days. LPN-A stated she did see the long hairs on R3’s upper lip and chin while administering medications this morning. LPN-A stated she was aware the facial hair bothered R3; she would go back and assist R3 with hair removal in a little bit. During an interview on 3/18/26 at 12:41 p.m., regional director of services (RDS) stated facial hair removing and grooming typically occurs on bath days. RDS stated the expectation is facial hair on women is removed as it grows, as it is care planned, and generally on bath days. RDS confirmed R3 has an order to shave on bath days and there were no documented refusals of	F0677		

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F0677 SS = D	Continued from page 9 grooming/hygiene care. RDS stated it is important the resident's grooming needs are met, especially if the lack of grooming was upsetting to the resident.	F0677		
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, interview, and document review, the facility failed to ensure proper food storage for 2 of 2 resident refrigerators that contained undated and unlabled food. Findings include: During observation on 3/18/26 at 11:46 a.m., the 2nd floor refrigerator located near the dining room contained an undated and unlabeled yogurt container 3/4 full with a pasta salad. A 2nd undated and unlabeled yogurt container was 3/4 full with soup. A sign on the refrigerator stated "stored items should contain the date placed in the fridge, use-by date (3 days from the original date), resident name, and room number. Any items with missing information will be discarded immediately. Not to be stored in a re-used single use container i.e. cottage cheese and salad dressing	F0812		

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ST CRISPIN LIVING COMMUNITY	**213 PIONEER ROAD , RED WING, Minnesota, 55066**

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F0812 SS = D	Continued from page 10 containers cannot be reused for food storage. Following the 3rd day, items and containers will be disposed of. [Facility name] will not be responsible for returning containers, they will be discarded." During an interview on 3/18/26 at 11:53 a.m., dietary aide (DA)-A stated dietary staff check the temperatures of the resident refrigerator however housekeeping is responsible for cleaning the inside and verifying food is labeled and dated. During an interview on 3/18/26 at 12:11 p.m., housekeeper (H)-A stated they are responsible for cleaning the dining rooms and common areas. They do not clean resident use refrigerators. During an observation on 3/18/26 at 3:25 p.m., the 1st floor refrigerator located near the dining room contained a clear plastic container of fresh pineapple. The container had a room number however was not dated. During an interview on 3/18/26 at 3:37 p.m., the dietary manager (DM) stated dietary staff are responsible for checking the temperature of the refrigerators however housekeeping cleans and checks dates of the food twice a week. The DM also stated staff "have a habit" of putting their personal food items in the refrigerator. During an interview on 3/18/26 at 3:55 p.m., the environmental services director stated dietary staff are responsible for checking the temperature of the refrigerators. One housekeeper is responsible for cleaning resident rooms on each floor. A "float" housekeeper is responsible for cleaning and checking the dates and labels of food items in the resident refrigerators weekly. The environmental services director stated staff should not be putting personal foods in the resident refrigerator and confirmed the items in question were not dated or labelled appropriately. During an interview on 3/19/26 at 7:20 a.m., H-B stated the resident refrigerator is checked weekly by the "common area housekeeper". During an interview on 3/19/26 at 10:37 a.m., the Regional Director of Clinical Services (RCS) stated housekeeping staff are responsible for cleaning the resident refrigerators and ensuring all food items are dated and labeled appropriately twice a week. A policy titled "Safe Food Storage and Handling for Food Brought in by Residents, Families, and visitors"	F0812		

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F0812 SS = D	Continued from page 11 dated 2019 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, use by date (max of 3 days) name and room number of resident. Storage of large quantities of food in oversized containers should be avoided". The policy also indicated "All residents should be verbally informed that a product has been placed for them in storage and that all products not used within 3 days will be discarded. Single-use containers such as cottage cheese and salad dressing containers cannot be re-used for direct food storage."	F0812		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;	F0842		

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F0842 SS = D	Continued from page 12 (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility	F0842		

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F0842 SS = D	Continued from page 13 failed to maintain a medical record that was accurately documented for 1 of 1 resident (R49), who was reviewed for weight monitoring. Findings include: R49's quarterly Minimum Data Set (MDS) assessment dated 12/16/25 indicated R49 had moderate cognitive impairment with no behaviors. R49 required substantial/maximal assistance with personal hygiene, showering/bathing, and upper body dressing. R49 was dependent on facility staff for lower body dressing, position transfers, and toileting. R49's diagnosis included ischemic heart disease (a condition where reduced blood flow to the heart muscle, usually caused by plaque buildup, causes oxygen deprivation), generalized muscle weakness, dementia (a decline in mental ability), and dysphagia (difficulty swallowing, often caused by dementia, can lead to malnutrition and dehydration). R49's provider orders included an order to obtain daily weights for registered dietician review on 4/8/25. R49's dietary supplements were discontinued on 1/26/26. During record review, R49's daily weights fluctuated with inconsistent readings noted at several intervals. Weight measurements included: -3/16/25: 132 -4/9/25: 128 -4/22/25: 129 -4/23/25: 128 -8/4/25: 123 -8/13/25: 134 -8/18/25: 118 -8/19/25: 130 -11/19/25: 142 -12/14/25: 100	F0842		

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F0842 SS = D	Continued from page 14 -12/19/25: 213 -12/24/25: 141 -3/12/26: 145 R49’s dietary supplements were adjusted on the following dates: -3/21/25: start Glucerna (nutritional supplement drink) 8 oz in the morning w/breakfast -3/27/25: increase Glucerna 8 oz twice per day -4/15/25: change to Ensure (nutritional supplement drink) 8 oz twice per day -12/15/25: change to Ensure 8 oz daily -1/26/26: discontinue supplement During an interview on 3/19/26 at 12:33 p.m., Regional Director of Services (RDS) reviewed R49’s weight documentation; confirmed weight documentation is inconsistent and likely incorrect. RDS stated inaccurate weight documentation should have been deleted. During an interview on 3/19/26 at 2:23 p.m., registered dietician (RD) stated R49’s weight has fluctuated for some time. RD stated she had previously asked facility staff to assist her with getting and documenting accurate weights. RD stated she asked for a weight verification order on 3/11/26; obtain resident weight two times x 1 week on 3/12/26 and on 3/15/26. A weight was documented on 3/12/26, but there was no documentation of weight in the treatment administration record (TAR) nor a progress note indicating why the order was not completed on 3/15/26. RD stated it has been difficult to make dietary supplement recommendations due to the inaccuracy of R49’s documented weights. During interview on 3/19/26 at 3:36 p.m., RDS confirmed again the inaccurate weights for R49 should have been deleted. RDS confirmed how difficult it could have been to manage R49’s dietary supplements when the documented weights were inaccurate. RDS stated it is important to get accurate weights and document appropriately to ensure residents get the correct treatment based on	F0842		

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F0842 SS = D	Continued from page 15 accurate information. A facility policy for accurate charting was requested and not received.	F0842		
F0881 SS = D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure proper antibiotic time out follow-up and ensure that appropriate antibiotics were utilized to prevent potential antibiotic resistance for 1 of 1 resident (R55) reviewed for multiple urinary tract infections. Findings include: R55s quarterly Minimum Data Set (MDS) assessment, dated 02/17/2026 identified R55 no cognition impairment, and substantial assistance with activities of daily living. R55 had diagnoses including hypertensive heart failure, diabetes mellitus with diabetic chronic kidney disease, and benign prostatic hyperplasia (prostate enlargement) with lower urinary tract symptoms. R55's January 2026 medication administration record (MAR) identified R55 was administered Macrobid (nitrofurantoin) 100 mg capsule, by mouth 2 times a day from 1/13/26 to 1/18/206 for urinary tract infection. Review of R55's medical record identified a urine analysis was completed on 01/10/26, result received on 1/11/26 indicated positive urine analysis. Urine culture results received on 1/15/26 indicated organisms identified as Proteus mirabilis with sensitivity to the following antibiotics: Ampicillin, Piperacillin /tazobactam, Cefazolin, Ceftazidime, Ceftriaxone, Cefepime, Aztreonam, Ertapenem, Meropenem, Gentamicin, Tobramycin, Levofloxacin,	F0881		

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NAME OF PROVIDER OR SUPPLIER **ST CRISPIN LIVING COMMUNITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **213 PIONEER ROAD , RED WING, Minnesota, 55066**		

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F0881 SS = D	Continued from page 16 Trimethoprim/Sulfamethoxazole. R55 was treated with an antibiotic not sensitive to the organism identified based on the urine culture result. R55's 72-Hours Antibiotic time out (a formal structured reassessment of a patient antimicrobial therapy conducted 48-72 hours after initial administration of antibiotic) review completed on 1/16/26 indicated McGeer 's Criteria (standardized surveillance definition used to identify and track infections such as urinary tract infection) to treat indicated, met. R55's record review indicated McGeer 's Criteria and culture was not met. R55 's March 2026 MAR identified R55 was administered ciprofloxacin 250 mg by mouth 2 times a day from 03/6/26 to 03/13/26 for urinary tract infection. Review of R55's medical record identified no urine analysis was ordered or completed before or after the start of the antibiotic. R55's 72 -Hours Antibiotic time out review completed on 3/10/26 indicated, McGeer 's Criteria to treat was not met, and culture or imaging test did not confirm infection. During an Interview on 3/19/2026 11:19 a.m., the infection preventionist (IP) acknowledged 72 -Hours Antibiotic time out reviews completed on 1/16/26 and 3/10/26 lacked accuracy and follow up on issues identified. Facility policy titled: Antibiotic Stewardship Program and Community Protocols reviewed on 3/2025 indicated, based on review of the clinical situation, pertinent lab and diagnostic tests, the provider and nursing associate will identify whether antibiotics are warranted or whether those that have already been started should continue or change.	F0881		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 7, 2026

Administrator
St. Crispin Living Community
213 Pioneer Road
Red Wing, MN 55066

Re: Reinspection Results
Event ID: 1E3F3D-H2

Dear Administrator:

On May 4, 2026, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 19, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 7, 2026

Administrator
St. Crispin Living Community
213 Pioneer Road
Red Wing, MN 55066

RE: CCN: 245449
Cycle Start Date: March 2, 2026

Dear Administrator:

On March 12, 2026, we notified you a remedy was imposed.

On May 7, 2026, the Minnesota Departments of Health and Public Safety completed revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 1, 2026.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 27, 2026, be discontinued as of April 1, 2026. (42 CFR 488.417 (b))

In our letter of March 12, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 27, 2026. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

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