DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 7, 2023

Administrator
Villa St. Vincent
516 Walsh Street
Crookston, MN 56716

RE: CCN: 245484
Cycle Start Date: June 29, 2023

Dear Administrator:

On August 16, 2023, the Minnesota Department(s) 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 28, 2023

Administrator
Villa St. Vincent
516 Walsh Street
Crookston, MN 56716

RE: CCN: 245484
Cycle Start Date: June 29, 2023

Dear Administrator:

On June 29, 2023, 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:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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 September 29, 2023 (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 December 29, 2023 (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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245484	A. BUILDING _____ B. WING _____	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ST VINCENT	516 WALSH STREET CROOKSTON, MN 56716

(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 On 6/26/23 through 6/29/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1),	E 041		8/4/23

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

Electronically Signed | 08/04/2023

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.

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E 041	Continued From page 1 §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the	E 041		

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E 041	Continued From page 2 material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..	E 041		

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E 041	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to install generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.1.1.16.2 and 6.4.1.1.17, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 5.6.5.2, 5.6.5, 5.6.5.6, 5.6.5.6.1, and 5.6.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 6/27/23 between 8:00 a.m. and 11:00 a.m., the generator documentation was reviewed with the director of plant operations. There was no evidence the generator was inspected on an annual basis. The director of plant operations stated there was no evidence of the annual inspection.	E 041	During survey it was noted that annual inspections had not been completed on our generator. This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. 1. Corrective Action for Resident Affected: No residents were found to have been affected. A full generator inspection was completed on Level 5 - 4 Hour Load Bank Test on 1/24.2023 by Allen Caster of Ziegler. Level 2 Inspection on 2/24/2023 by Allen Caster of Ziegler. Level 9 Inspection on 2/24/2023 by Allen Caster of Ziegler There were no issues noted upon inspection of the generator by Ziegler. 2. Action as it applies to others: As per #1. No residents have the ability to be affected as these have all been completed. We have a signed contract with Ziegler Power Systems to conduct our Maintenance, Preventative Maintenance and Inspections on our generators on a Quarterly, Semi Annually and Annual basis. They also conduct full load bank (4-hour) tests to meet the requirement and be compliant. We went over the formula to verify that we are running at, at least a 30% capacity. Our full load amps are 528 amps and 226	

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E 041	Continued From page 4	E 041	amps. Our generators run at 210 Amps which is well above the 162 Amps and 68 Amps needed to meet the 30% criteria. This is based on the manufacture□s guidelines and the technician□s instruction. 3. Measures put into place to prevent further issues: An annual check has been placed into TELS to further ensure inspections are on a reoccurring basis. Education reminders were completed on 7/27/23 with our Maintenance Team on the expectation for completing this annual inspection. 4. How the facility will monitor: An organized binder has been created to hold the necessary documentation to verify this plan. The initial audit and inspection was completed by: Allen Caster & Brian Kelly. This was reviewed and signed by Lindsey Erdman on 8/12/22 (3-year Contract effective 9/01.2022 through 8/31/2025 with facility administrator and will be monitored for TELs compliance through quality council. EVS director will be responsible for auditing and compliance. Substantial compliance was met 7/28/2023	
F 000	INITIAL COMMENTS On 6/26/23 through 6/29/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		

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F 000	Continued From page 5 The following complaints were reviewed with no deficiencies cited: H54843027C (MN93960), H54843028C(MN93259), H54843029C (MN87474), H54843031C (MN92979), H54843032C (MN92346), H54843033C(MN92970), H54843046C (MN86726), H54843047C (MN93016), H54842997C (MN86656) and H54842998C (MN92746) 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.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 580		8/4/23

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F 580	Continued From page 6 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician reagrding changes in skin/weight requiring potential provider interventions for 1 of 4 residents (R64)	F 580	During the annual survey it was noted that the facility failed to notify the physician regarding changes in skin/weight requiring potential provider	

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F 580	Continued From page 7 reviewed for skin conditions; and 1 of 2 (R85) residents reviewed for edema. Findings include: R64's admission Minimum Data Set (MDS) dated 4/30/23, identified R64 had a moderate cognitive impairment and was at risk for pressure ulcers but had no curren open areas. R64's nursing progress note(s) identified the following: - 5/31/23 at 9:32 a.m., identified an area on the tip of R64's left great toe has a 0.4-centimeter (cm) x 0.4 cm soft gold scab. No drainage. Just to the other side of scabbed area was another dry scab measuring 0.2 cm x 0.4 cm. Redness on the tip of toe is 2-2.5 cm. The unit manager was updated. Staff applied betadine and a dressing. The second toe tip was also red with no open areas or soft spots seen. No edema noted in lower extremities. No other areas of concern. - 5/31/23 at 11:05 a.m., identified a fax update was sent to R64's medical provider regarding her left great toe, however, the medical record lacked a response and not further follow up to the provider was identified. R64's physician progress note dated 6/14/23, identified there was concern with some sores on R64's great toe. It almost looked like shoes were too tight and rubbed. R64 had a little bit of infection going on there was some early mild cellulitis. Maybe a little blister also. Plan: Cephalexin for the infected toes and to recheck if not improving. During an interview on 6/26/23 at 5:04 p.m., R64	F 580	interventions for R64 for skin conditions and R85 for edema. This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. 1. Corrective Action for Residents Affected: -R64 continues to have toe wound. Resident has been seen by Podiatry on 7/18/23. They have been referred to vascular surgery with a dx of vascular ulcer. Treatment order of betadine to toe daily is still current per MD order. Prevalon boots and a foot cradle (tenting of sheets) are in place added protection with a treatment order in place. The care plan has been updated to reflect these changes. - R85□s weight order has been updated with parameters to indicate when to update the provider of a weight gain. Parameter are the following; 3lbs in 24 hours and 5 lbs in one week. The care plan has been updated to reflect these changes. 2. Action as it applies to others: All residents have the ability to be affected. All residents with any open skin areas have been assessed and communication has been sent to the provider on any new areas identified by 8/11/23. All residents with current edema and/or orders for daily	

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F 580	Continued From page 8 stated her toe was infected. At first, they said it was an ingrown nail but now they say something about a pressure ulcer. R64 did not know for sure. During an interview on 6/28/23 at 10:09 a.m., registered nurse (RN)-A stated R64's physician saw R64 while on rounds on 6/14/23, and ordered an antibiotic. The area was first noted on 5/31/23, and a fax was sent to the physician's office on 5/31/23; however, the chart did not identify a response from the provider. RN-A stated a lot of the time the physician's clinic nurse would call over, but no documentation would be done. During an interview on 6/28/23 at 2:44 p.m. the director of nursing (DON) stated staff were expected to assess a skin concern, update the provider if indicated, document findings such as improvements and/or declines. The DON stated facility policy did not spell out when staff should re-attempt physician notification, but standing orders indicated a stage 2 or 3 wound the physician should be notified the next day. During a telephone interview on 6/28/23 at 4:51 p.m., R64's physician stated he was not notified of R64's wound until rounds on 6/13/23. It appeared to be an abrasion and it was a presumption on his part that R64's shoes were rubbing too tight. The area was inflamed and it was an early infection. The physician stated he would have expected to be notified sooner, however; it did not cause R64 any harm. The facility policy Prevention and Treatment of Skin Breakdown undated, identified maintaining intact skin was integral to resident health and wellness. Care and service were delivered to	F 580	weights have been reviewed and their orders reviewed to ensure there are weight parameters in place for notification on weight changes. 3. Measures put into place to prevent further issues: The policy and standing orders will be updated to reflect the current practice by 8/11/23. Education regarding skin conditions and weight management along with notification of the provider will be provided to all associated dietary and nursing staff on or before 8/11/23. 4. How the facility will monitor: Audits will be conducted weekly on 4 random residents with current skin related issues and 4 random residents with weight monitoring in place to ensure notification has been completed in a timely manner x 3 months and will be reviewed through quality council for continued need for audits based on compliance. DON and/or DON designee will be responsible for the compliance and audits. Substantial compliance will be achieved 8/14/23.	

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	245484	A. BUILDING _____ B. WING _____	C 06/29/2023

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F 580	Continued From page 9 maintain skin integrity and promote skin healing if skin breakdown should occur. If a resident was admitted with impaired skin integrity or a new pressure injury or lower extremity wound developed the licensed nurse implemented included the following items: 1. Documentation of the skin impairment was completed in the medical record. Staging of pressure injury was completed as necessary by trained licensed associates. Other lower extremity wounds would be described as partial thickness or full thickness loss. 2. Standing orders/protocol for skin wound were initiated. 3. Notify attending provider, resident, and resident representative. Attending provider determined wound type and may provide additional orders. 4. Evaluate current pressure reduction interventions and revise resident centered care plan. R85's admission MDS dated 6/12/23, identified R85 was alert and oriented. Diagnoses included chronic obstructive pulmonary disease (COPD), cellulitis of the left and right lower limbs, edema, and hypertension. R85's physician orders dated 6/7/23, identified R85 should have a daily weight; however, the physician order did not provide parameters which directed staff when to contact R85's physician. R85's Electontic Treament Adminsitration Record (ETAR) dated 6/1/23-6/27/23, identified the following daily weights: 6/7/23 393.5 lbs 6/8/23 388.7 lbs 6/9/23 386.5 lbs 6/12/23 398.2 lbs (a 11.7 lbs weight gain)	F 580		

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F 580	Continued From page 10 6/13/23 399.6 lbs R85's nursing progress note dated 6/13/23 at 11:48 a.m., identified R85 was evaluated by his physician on rounds. R85 requested to have as needed nebulizer medications in his room to self-administer. However, the nursing progress note did not identify if R85's physician was notified of R85's 13.1 lbs weight gain. R85's physician progress note dated 6/13/23, identified R85 was evaluated by his physician. The facility was doing daily weights as R85 did have chronic edema issues. R85's legs were even losing and R85 did not want them wrapped overnight and really did not want to wear any stockings. Generally, R85 tried to elevate his legs. The progress note did not identify R85's physician was notified of his 13.1 lbs weight gain. The weight gain was not addressed in the progress note. During an interview on 6/28/23 at 7:52 a.m., LPN-A stated weights were usually documented in the resident's ETAR. Nursing would remind the nursing assistants who needed a weight that day, but it was also on the form Group 1 B form. After the nursing assistants reported the weight, LPN-A entered it into the computer. Notifying the physician really depended upon the order: some were over 3 lbs weight gain, some were 5 lbs over. Nursing would do an assessment such as lung sounds, check for edema and notify the physician. If the physician order did not give specific parameters, staff would go by the 3-5 lbs protocol. LPN-A stated sometimes the physician order didn't say, especially if the resident took a diuretic. If that happened, staff would check with the physician to see what he/she wanted and	F 580		

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F 580	Continued From page 11 update the order. Some physicians wanted to be notified weekly. R85 had a lot of swelling and cellulitis (common, potentially serious bacterial skin infection. The affected skin is swollen and inflamed and is typically painful and warm to the touch.) in his legs. During an interview on 6/28/23 at 8:10 a.m. LPN-B stated when you enter a weight into the computer, you're supposed to check the previous weight. If the weight was "off", you usually obtained a re-weigh and if still "off", notify the physician and go from there. Usually, a nursing progress note would be entered to say what you did. LPN-B stated R85 was seen by his physician on 6/13/23, but the note did not say if the physician was notified of his weight gain, and it should have been documented. During an interview on 6/28/23 at 10:27 a.m., RN-A stated staff were instructed to obtain a daily weight for R85 due to his diuretic and his edema. When a physician did rounds, resident vitals were printed for the physician to review. However, R85's physician progress note dated 6/13/23, did not identify if the physician had been notified of R85's weight gain. On 6/28/23 at 12:37 p.m., a call to R85's physician was attempted, however, no response was received. During an interview on 6/28/23 at 3:11 p.m. the DON stated staff were expected to notify the physician of a weight gain to prevent further complications such as cellulitis or fluid overload. The facility procedure Height and Weight Measurement undated, identified if there was a 5	F 580		

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F 580	Continued From page 12 lbs difference than previous weight either up or down, it was recommended to re-weigh again. Report to team leader or charge nurse and document procedure in medical record. However, the procedure did not direct staff when to notify the physician of a resident weight gain. The facility policy Weight Monitoring and Documentation effective date 2012, identified the physician and family/responsible party would be notified of any significant weight change.	F 580		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) antipsychotic medication section was accurate for 1 of 24 residents (R83) reviewed for MDS assessments. Findings include: R83's Admission Orders dated 4/11/23, included orders for buspirone (antianxiety medication) 10 milligrams (mg) by mouth two times (BID) a day for anxiety, venlafaxine (an antidepressant medication) 150 mg every day and venlafaxine 75 mg every morning. R83's admission MDS, dated 4/19/23, identified R83 did not receive any of the following medications under section section N: antianxiety and antidepressant; even though R83's	F 641	During the annual survey it was noted that 1 MDS assessment for R83 was inaccurate for psychotropics in section N of the MDS. This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. 1. Corrective Action for Residents Affected: R83□s MDS assessment from 4/11/23 was modified on 7/31/23 to reflect the accurate medications R83 takes. The	8/4/23

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F 641	Continued From page 13 Admission Orders dated 4/11/23, identified R83 had orders for antianxiety and antidepressants. During interview on 6/28/23, registered nurse (RN)-C stated RN-C completed R83's MDS dated 4/11/23. RN-C didn't believe R83 received any psychotropic medications when he was admitted. RN-C was not very familiar with all the medications that were classified as psychotropic medications and had to look the medication classifications up to find which ones required monitoring. R83's admission orders did indicate R83 was taking both antidepressant and antianxiety medications since his admission and the medications should have been documented in section N: Medications, under those classifications as having received daily during the review period. When interviewed on 6/28/23, the director of nursing (DON) stated R83's MDS section N: Medications was not coded accurately. It was important to code resident medications correctly so the psychotropic care area assessment was triggered and prompted the concern to be addressed on the care plan. The undated facility policy Comprehensive Assessment and Care Planning, identified the comprehensive assessment must accurately reflect the resident's status and each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. The care area assessment was designed to assist the assessor to systematically interpret the information recorded on the MDS and focus on key issues identified. The Centers for Medicare and Medicaid Services	F 641	careplan was reviewed to ensure accuracy. 2. Actions as it applies to others: All residents who are on psychotropics have the ability to be affected. All residents who are on psychotropic medications have had their most recent MDS reviewed for accuracy. Any inaccurate MDS□s will be modified by 8/11/23. 3. Measures put into place to prevent further issues: Education was completed for all staff that complete section N on the MDS on or before 8/11/23 on what medications fall into that category. 4. How the facility will monitor: Audits will be conducted on 3 random resident MDS□s per week on section N to ensure accurate coding was completed x 3 months. Audits will be reviewed through quality council for continued need for audits based on compliance. DON and/or MDS coordinator will be responsible for the compliance and audits. Substantial compliance will be achieved 8/14/2023.	

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F 641	Continued From page 14 (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2019, identified the RAI was used to help ensure staff reviewed the resident holistically to help provide quality care and quality of life. The manual reviewed each section of the RAI including, "Section N: Medications." This directed to record the number of days any type of the selected medication was received by the resident during the review period. Further, the manual directed, "Medications that have more than one therapeutic category and/or pharmacological classification should be coded in all [bold font] categories/classifications assigned to the medication, regardless of how it is used."	F 641		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide meaningful activities for 1 of 2 residents (R29) who was dependent on staff for activities. Findings include:	F 679	During survey it was identified that a resident in MCU was alone in her room and did not have activities provided as careplanned. This plan of correction constitutes the facility's credible allegation of compliance.	8/4/23

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F 679	Continued From page 15 R29's admission Minimum Data Set (MDS) dated 4/5/23, identified R29 had severe cognitive impairment. The interview of activity preferences indicated it was somewhat important to R29 to have books, magazines and newspapers to read, have pets around and to keep up with the news. It was very important to R26 to listen to the music she liked, do activities with groups of people and to participate in religious services. R29's care plan dated 5/24/23, indicated R29's activities of interest were to attend religious services, crotchet, bingo, exercises, Spanish or country music, looking at magazines, watching westerns on television, pets, smaller group activities, spending time outdoors and socializing with family. A goal was set to become aquatinted and comfortable in surroundings by attending group activities of interest three to four times per week and independent pursuits daily. Interventions directed staff to turn on Spanish music or aroma therapy when R29 showed signs of anxiety or restless, offer and assist to programs of interest, religious services, and escort outside if weather allows. R29's Individual/Group Daily Activity Involvement Record June 2023, documented R29's recorded activities for the month. It listed nineteen different group activities which could be recorded, including religious services, church, baking, music, sing along, exercises and outside activity. R29 participated in two bingo activities, one church, one animal therapy and one walking club. R29 refused 10 offers of group activities and was unavailable 18 times. R29 participated in independent activity of walking, social or phone visiting and recliner or bed rest as well as greetings.	F 679	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. 1. Corrective action for the resident affected: R29□s quarterly review was completed on 07/05/2023. Updates were made to her care plan and goals. R29 also receiving 1:1 visits 1-2x□s per week with one documented weekly in Matrix. R29 receives independent materials from the book cart weekly or as needed. 2. Actions as it applies to others: All 1:1 resident care plans will be reviewed for appropriate actions by 8/11/23 with subsequent careplan updates completed. 3. Measures put into place to prevent further issues: Staff education was completed for all activity staff on the importance of communication, when residents are not meeting current goals so adjustments can be made to care plans and the department as a whole can ensure resident□s needs are met by 8/11/23. 4. How the facility will monitor: R29□s participation, attendance form and goal outcomes will be reviewed weekly by the Activity Director x 3 months and as needed as determined through quality council. This will include weekly audits x 3 months on 4 random 1:1□s to ensure resident□s needs are met. Audits will be reviewed through quality council for	

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F 679	Continued From page 16 During observation on 6/27/23, from 8:00 a.m. to 11:00 a.m. R29 was seated in a chair in her room with no lights, music television or interaction from staff aside from required care (medications, toileting, and meal trays) services from staff. There were no books or magazines visible in the room. R29 appeared anxious and was twisting and turning a soaker pad cloth she took off the chair. During observation on 6/28/23, from 9:00 a.m. to 1:00 p.m. R29 was sitting in a chair in room without lights, music, television or interaction from staff aside from required care (medications, toileting, meal trays) services from staff. R29 appeared anxious and was twisting and turning a soaker pad cloth she took off the chair. There were no books or magazines visible in the room. During interview on 6/28/23, activity assistant (NA)-D stated NA-D tried to invite R29 out of her room every day but she frequently refused. She liked to crotchet and NA-D saw R29 trying to crochet on occasion. It was usually dark and quiet in her room with the television and radio off. NA-D tried to turn on her television but R29 would just get up and turn it off. NA-D thought R29 should have one to one visits but R29 was not on the list for 1:1's. When she recorded unavailable on R26's activity log that meant that she was sleeping and she did not awaken her. The recorded independent activity of greeting indicated NA-D went to R29's room and greeted her for the day. NA-D would talk with the activity director to have R29 set up for 1:1 visits and see about doing some stimulation things in her room, as she rarely participated in any group activities.	F 679	continued need for audits based on compliance. The Activity Director will be responsible for the compliance and audits. Substantial compliance will be achieved by 8/14/23.	

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F 679	Continued From page 17 When interviewed on 6/28/23, registered nurse (RN)-C stated R29 did have knitting in her room but RN-C had to take away her crotchet hook as it had gotten lost in her chair and she was afraid R29 would be injured from it. R29 was cognitively impaired and probably did not understand what she was refusing when staff offered to take her to a group activity. RN-C knew R29 loved going outside and used to watch her television a lot but no longer did that. R29's family had been taking her out on outings but had not done so in awhile. R29 did not let the staff keep the room lights on. During interview on 6/28/23, the activity director (AD)-C stated she had just discussed R29's participation in activities with the activity assistant NA-D. NA-D was new to her position and frequently was pulled to the floor to do NA duties. NA-D indicated R29 would benefit with 1:1 activity as she was refusing to come out of her room, as well as needing some sensory stimulation. NA-D reported to AD-C that R29 used to crotchet and knit in her room but was no longer doing that either. AD-C instructed the activity aide to get the residents out and interested in the activity programing and the need for 1:1 visits would decrease. R29 was coming due for her quarterly reassessment and there was probably more that could be done for her. When interviewed on 6/28/23, the director of nursing (DON) stated the activity aide for the memory care was new to the position. If there was a change in a resident's participation with activities, an assessment and alternative activity should be provided and staff should look into the reason the participation had changed. The agency's policy Wellness dated 2017,	F 679		

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F 679	Continued From page 18 indicated the purpose was to involve each resident in an ongoing program of activities that was designed to appeal to his or her interests and needs and to enhance the resident's highest practicable level of physical, mental and psychosocial well-being. Each resident's activity program should be individualized meeting their interests and needs with the resident's desired outcomes, including one to one activities.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, interview and document review, the facility failed to ensure care planned interventions to promote wound healing were implemented for 1 of 4 residents (R64) reviewed for skin conditions. Findings include: R64's admission Minimum Data Set (MDS) dated 4/30/23, identified R64 had a moderate cognitive impairment and was at risk for pressure ulcers but had no open areas. R64's Pressure Ulcer/Injury Care Area Assessment (CAA) dated 5/5/23, identified a	F 684	During the annual survey it was noted that the facility failed to ensure careplanned interventions to promote wound healing were implemented for R64 for skin conditions. This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and	8/4/23

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F 684	Continued From page 19 Braden Assessment (a standardized tool to assess pressure ulcer risk) score of 15 which put her at risk for skin breakdown. R64 was able to turn in bed with minimal assist and was encouraged to do so as frequently as she would allow and tolerate. R64's skin was checked weekly by a licensed nursing staff and as needed. All interventions were in place and staff would continue to observe and update as need arose. Goal was for surgical wounds to heal with no complications. R64's care plan dated 5/30/23, identified R64 had impaired skin integrity. Staff were directed to apply Prevalon boots (help reduce the risk of bedsores by keeping the heel floated, relieving pressure) at all times when R64 was in bed, tent blankets at the foot of the bed to keep blankets off R64's feet, and to check R64's skin weekly by a licensed nurse with weekly bath/shower. Caregivers were to report skin irritations and bruising to team leader. The facility form Group 1 B undated, identified R64 needed Prevalon boots while in bed and to tent blankets off feet when in bed. During an interview on 6/26/23 at 5:04 p.m., R64 stated her toe was infected. At first, they said it was an ingrown nail but now they say something about a pressure ulcer. R64 did not know for sure. During an observation on 6/27/23 at 4:13 p.m., R64 was lying in bed while watching TV. R64 was not wearing Prevalon boots. During an observation on 6/28/23 at 9:51 a.m., licensed practical nurse (LPN)-A entered R64's	F 684	state law requirements. 1. Corrective action for the resident affected: R64□s careplan was updated on 5/30/23 to indicate the use of Prevalon boots and a foot cradle to be offered and used. Nursing treatment order and care sheet were updated on 6/29/23 to ensure staff document on compliance and document refusals if indicated. 2. Actions as it applies to others: All residents who have pressure injuries have the ability to be affected. All residents with current pressure injuries have had their care plan reviewed and updated to reflect current interventions by 8/11/23. 3. Measures put into place to prevent further issues: Education was provided to all associated nursing staff on or before 8/11/23 on updating the careplan for current interventions. The policy was reviewed. 4. How the facility will monitor: Audits will be conducted on 4 random residents weekly who have skin related careplanned interventions in place to observe for compliance x 3 months. Audits will be reviewed through quality council for continued need for audits based on compliance. DON and/or DON designee will be responsible for the compliance and audits. Substantial compliance will be achieved by 8/14/23.	

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	245484	A. BUILDING _____ B. WING _____	C 06/29/2023

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F 684	Continued From page 20 room to perform R64's dressing change to her left great toe. R64 was lying in bed without Prevalon boots on. - At 9:53 a.m., LPN-A stated the area measured 0.5 cm x 0.7 cm. The area was a dry, firm scab which was tender to the touch. LPN-A stated because the area was scabbed over and staff were unable to determine the depth of the wound it would be unstageable, "I guess". R64 did not currently wear shoes but did wear shoes with therapy prior to the wound. It started as a pinpoint scab.. R64 was taking an antibiotic, and this helped the area. LPN-A then left the room without offering or applying R64's Prevalon boots. During an interview on 6/28/23 at 11:29 a.m., nursing assistant (NA)-A stated R64 had a sore toe. R64 liked being in bed, but the nurses applied a dressing to R64's toe and she wore gripper socks instead of shoes. However, NA-A knew of no other interventions for R64. During an interview on 6/28/23 at 11:33 a.m., LPN-A stated R64 did have Prevalon boots in her room but she did not wear them. LPN-A stated she did not know why R64 did not wear the Prevalon boots and did not document when R64 did not wear them. During an interview on 6/28/23 at 10:09 a.m., registered nurse (RN)-A stated R64's physician saw R64 while on rounds on 6/14/23, and ordered an antibiotic. There was a potential for pressure injury and it was care planned R64 should have Prevalon boots on while in bed. The electronic treatment administration record (ETAR) did not identify nor require nursing to ensure R64's use of Prevalon boots.	F 684		

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F 684	Continued From page 21 During an observation on 6/28/23 at 10:44 a.m., RN-A entered R64's room. R64 was lying in bed without Prevalon boots and R64 stated she did not know where they were. RN-A pulled the Prevalon boots out of the top dresser drawer and showed them to R64. RN-A did not offer to put them on and placed them back into the drawer before leaving the room. During an observation on 6/28/23 at 1:15 p.m., R64 continued to lie in bed without Prevalon boots. During an interview on 6/28/23 at 1:24 p.m., NA-B had some sores on her toes. Staff elevated her legs, and she did have some special boots at night when she was in bed. NA-B stated he did not work evenings so would not normally put them on. NA-B reviewed the facility form Group 1 B and stated R64 should have the Prevalon boots on when in bed. NA-B stated he would fix that and entered R64's room and applied the Prevalon boots. NA-B stated the Prevalon boots should always be offered, and nursing should be notified if R64 refused so it could be documented. During an interview on 6/28/23 at 2:44 p.m. the director of nursing (DON) stated if a resident was refusing an intervention, staff should document that and find an alternative intervention. The facility policy Prevention and Treatment of Skin Breakdown undated, identified maintaining intact skin was integral to resident health and wellness. Care and service were delivered to maintain skin integrity and promote skin healing if skin breakdown should occur. If a resident was admitted with impaired skin integrity or a new pressure injury or lower extremity wound	F 684		

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F 684	Continued From page 22 developed the licensed nurse implemented included the following items: 1. Documentation of the skin impairment was completed in the medical record. Staging of pressure injury was completed as necessary by trained licensed associates. Other lower extremity wounds would be described as partial thickness or full thickness loss. 2. Standing orders/protocol for skin wound were initiated. 3. Notify attending provider, resident, and resident representative. Attending provider determined wound type and may provide additional orders. 4. Evaluate current pressure reduction interventions and revise resident centered care plan.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely repositioning was offered for 1 of 4 residents	F 686	During the annual survey it was noted that the facility failed to ensure timely repositioning was offered for R26.	8/4/23

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F 686	Continued From page 23 (R26) reviewed for pressure ulcers. Findings include: R26's quarterly Minimum Data Set (MDS) dated 4/13/23, identified R26 had severe cognitive impairment and required extensive assistance with bed mobility and transfer assistance. Diagnoses included hemiplegia (one sided paralysis) and Alzheimer's disease. R26 was at risk to develop pressure ulcers, but currently had no unhealed pressure ulcers. R26's care plan dated 3/27/23, identified R26 was at risk for skin breakdown. Interventions included to schedule two baths per week, skin checks weekly by a licensed nurse, quarterly skin assessments, treat, reduce and eliminate risk factors, a wheelchair seat cushion, incontinence care after each incontinent episode and a turn and reposition schedule every two hours. During continuous observation on 6/27/23, from 9:20 a.m. to 12:00 p.m., R26 was assisted to lie down in her bed at 9:20 a.m. R26 was observed to have been placed in bed on her left side, facing the wall, with a blanket covering her. The door to her room was open and a stop sign banner was across the opening of the doorway. R26 was in the same position and no staff entered R26's room. At 11:54 a.m. nursing assistant (NA)-E entered R26's room, put on gloves and emptied R26 catheter into a graduate. NA-D entered the room with a mechanical lift and both nursing assistants transferred R26 from her bed to her wheelchair in preparation to go to the dining room for lunch. It had been two hours and 34 minutes since R26 was last repositioned.	F 686	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. 1. Corrective action to the resident affected: R26□s careplan was reviewed to ensure proper repositioning was in place on the careplan and R26 TAR nursing orders updated to indicate that staff offer repositioning q2hrs with special instructions to document refusals every shift. 2. Action as it applies to others: All residents with a Braden of 12 or less will have etar orders placed for repositioning including refusals by 8/14/23. 3. Measures put into place to prevent further issues: Education has been provided to all associated staff on or before 8/11/23 on the importance of repositioning and following the careplan. Nurses have been educated on the new orders entered into the TAR for verification of resident positioning in bed on or before 8/11/23. The policy was reviewed. 4. How the facility will monitor: Audits will be conducted on 4 random residents weekly who are on a two hour repositioning schedule while in bed x 3	

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F 686	Continued From page 24 During interview on 6/27/23, NA-D stated staff assisted R26 to turn and reposition every one to two hours. They should have come in and repositioned her at some time that morning but it had been such a busy morning, they never had the chance to. When interviewed on 6/28/23, registered nurse (RN)-C stated it was important for staff to go into R26's room and check on her to see if she needed toileting or to be repositioned. The staff were instructed on the importance to turn and reposition residents as care planned. During interview on 6/28/23, the director of nursing (DON) stated her expectation was for residents to be repositioned according to their care plan to prevent the development of pressure ulcers. The facility's undated policy Repositioning indicated nursing staff would reposition residents at moderate or greater risk of skin breakdown or pressure injury every two hours or more often as needed.	F 686	months to ensure proper repositioning is occurring. Audits will be reviewed through quality council for continued need for audits based on compliance. DON and/or DON designee will be responsible for the compliance and audits. Substantial compliance will be achieved 8/14/2023.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 732		8/4/23

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F 732	Continued From page 25 (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure required nurse staffing information was updated daily with schedule changes. This had the potential to affect all 88 residents, staff and visitors who could wish to review this information. Findings include: During observation on 6/26/23 at 11:30 a.m., the facility daily staff posting was posted on the wall	F 732	During the annual survey it was noted that the facility failed to ensure required nurse staffing information was updated daily with schedule changes. This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies.	

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F 732	Continued From page 26 at station 230 by the desk at waist level. The posting included the date, direct care nursing staff shifts, numbers, census and total hours worked. The facilities daily staff postings and the actual working schedules were reviewed from 6/19/23 to 6/25/23. The hours, shift from the scheudled did not match the nurse staff posting hours ans shifts per nursing discipline when the schedule was changed. During interview on 6/27/23 at 5:05 p.m., the director of nursing (DON) and the trained medication aide (TMA-A) who is also responsible for scheduling stated they did not update the daily staff postings. They only updated the actual working schedule with any scheduled changed. They both were unaware they needed to update the daily staff posting with the current schedule changes. The DON stated they should be updating the daily staff posting so the residents and visitors were aware of who is working in the building for that day. A policy for daily staff posting was requested none received.	F 732	The plan of correction is prepared and/or executed in accordance with federal and state law requirements. 1. Corrective action to the resident affected: No resident was affected, see action 2. 2. Action as it applies to others: A new process has been developed to ensure this information is updated in one central location daily and with staffing changes. This had the ability to affect all residents, visitors, staff who could wish to review this information. 3. Measures put into place to prevent further issues: Education on or before 8/11/23 will be provided to the staffing coordinator and night nurses to whom will run and update the report daily with changes 7 days a week. The policy will be reviewed and updated by 8/11/23. 4. How the facility will monitor: Audits will be conducted on 3 times a week on accuracy of the posted nursing hours report x 3 months based on posting of the hours and actual staffing and census. Audits will be reviewed through quality council for continued need for audits based on compliance. DON and/or DON designee will be responsible for the compliance and audits. Substantial compliance will be achieved 8/14/2023.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		8/4/23

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F 756	Continued From page 27 §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 756		

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F 756	Continued From page 28 Based on interview and document review, the facility failed to ensure the consulting pharmacist identified and reported medication irregularities for 1 of 5 residents (R26) reviewed for unnecessary medications. Findings include: R26's quarterly Minimum Data Set (MDS) dated 4/13/23, identified R26 had severe cognitive impairment. Diagnoses included heart disease and hypokalemia. R26's Physician Order Report dated 6/28/23, included orders for potassium chloride 20 milliequivalents orally every day for hypokalemia (low potassium blood level). The start date for the medication was listed as 10/9/2019. R26's laboratory results dated 1/19/21, identified R26 had a potassium level drawn with her labs on 1/19/21, and her primary physician had indicated it was normal. The medical record lacked evidence further potassium lab draws. The Monthly Consultant Pharmacy Summary notes June 2022 through June 2023, identified R26's medication regimen was evaluated by the consulting pharmacist (CP) each month, with no recommendations to evaluate R26's potassium supplementation or therapeutic blood levels. During interview on 6/28/23, the consulting pharmacist (CP) stated he had missed the fact R26 potassium wasn't checked since 1/19/21. CP was not concerned about her use of potassium but there should be a blood level done for due	F 756	During the annual survey it was noted that the facility failed to ensure that a potassium lab was completed during a pharmacy review. This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. 1. Corrective action to the resident affected: R26□s lab work was completed on 7/7/23 with the potassium level being within normal limits, as was her previous level. In addition, the provider ordered annual BMP□s for R26. The Consulting Pharmacist has verified that with R26□s current medications list and condition that an annual BMP is appropriate. This will be reviewed ongoing during quarterly assessment and careplanning time for R26. 2. Action as it applies to others: The Consulting Pharmacist will review all residents receiving Potassium for any outstanding lab work needing completion by 8/11/23. 3. Measures put into place to prevent further issues: All residents will receive BMPs annually per policy. Those on potassium will be scheduled per MD orders, annual at a minimum per standing.	

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F 756	Continued From page 29 diligence. When interviewed on 6/28/23, the director of nursing (DON) stated it would be important to monitor R26's potassium level periodically to ensure the dose was therapeutic and not causing harm. The facility's management changed all their facilities practice of drawing routine lab work every year to only when ordered by the resident's primary physician. The DON indicated it would be harder to make sure therapeutic drug levels were being monitored because the physician would have to specifically order drug levels to be drawn periodically for each resident.	F 756	4. How the facility will monitor: Audits will be conducted on 4 random residents that receive potassium medication weekly to ensure that appropriate lab work is ordered, completed x 3 months to ensure appropriate lab work is occurring. Audits will be reviewed through quality council for continued need for audits based on compliance. DON and/or DON designee will be responsible for the compliance and audits Substantial compliance will be achieved 8/14/2023.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §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- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this	F 757		8/14/23

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F 757	Continued From page 30 section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure laboratory monitoring was completed to prevent complications and ensure therapeutic dosing of potassium supplementation for 1 of 5 residents (R26) reviewed for unnecessary medications. Findings include: R26's quarterly Minimum Data Set (MDS) dated 4/13/23, identified R26 had severe cognitive impairment. Diagnoses included heart disease and hypokalemia. R26's Physician Order Report dated 6/28/23, included orders for potassium chloride 20 milliequivalents orally every day for hypokalemia (low potassium blood level). The start date for the medication was listed as 10/9/2019. R26's laboratory results dated 1/19/21, identified R26 had a potassium level drawn with her labs on 1/19/21, and her primary physician had indicated it was normal. The medical record lacked evidence further potassium lab draws. During interview on 6/28/23, registered nurse (RN)-C stated the last time R26 had her potassium level checked was on 1/19/21. RN-C stated she would bring the matter up to R26's primary physician when she was next seen. When interviewed on 6/28/23, the director of nursing (DON) stated it would be important to	F 757	During the annual survey it was noted that the facility to ensure laboratory monitoring was completed to prevent complications and ensure therapeutic dosing of potassium supplementation. This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. 1. Corrective action to the resident affected: R26's lab work was completed on 7/7/23 with the potassium level being within normal limits. In addition, the provider ordered annual BMP's for R26. The Consulting Pharmacist has verified that with R26's current medications list and condition that an annual BMP is appropriate. This will be reviewed ongoing during quarterly assessment and careplanning time for R26. 2. Action as it applies to others: Action as it applies to others: The Consulting Pharmacist will review all residents receiving Potassium for any outstanding lab work needing completion by 8/11/23. 3. Measures put into place to prevent further issues: All residents will receive BMPs annually per policy. Those on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245484	A. BUILDING _____ B. WING _____	C 06/29/2023

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F 757	Continued From page 31 monitor R26's potassium level periodically to ensure the dose was therapeutic and not causing harm. The facility's management changed all their facilities practice of drawing routine lab work every year to only when ordered by the resident's primary physician. The DON indicated it would be harder to make sure therapeutic drug levels were being monitored because the physician would have to specifically order drug levels to be drawn periodically for each resident.	F 757	potassium will be scheduled per MD orders, annual at a minimum per standing orders. 4. How the facility will monitor: Audits will be conducted on 4 random residents that receive potassium medications weekly to ensure that appropriate lab work is ordered, completed x 3 months to ensure appropriate lab work is occurring. Audits will be reviewed through quality council for continued need for audits based on compliance. DON and/or DON designee will be responsible for the compliance and audits Substantial compliance will be achieved 8/14/2023.	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following:	F 883		8/4/23

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F 883	Continued From page 32 (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure 3 of 5 residents (R71, R81, R83) were offered or received the	F 883	During the annual survey it was noted that the facility failed to ensure that 3 of 5 residents had the current CDC	

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F 883	Continued From page 33 pneumococcal vaccine in accordance with the Center for Disease Control (CDC) recommendations. Findings include: The CDC's Pneumococcal Vaccine Timing for adults dated 3/15/23, identified adults who have completed the pneumococcal vaccine series PCV13 (pneumococcal conjugate vaccine) at any age and PPSV23 (pneumococcal polysaccharide vaccine) after age 65. Should be offered the PVC20 (pneumococcal 20-valent conjugate vaccine) for adults 65 years or older who have already received PCV 13 (but not PCV15 or PCV20) at any age and PPSV23 at or after the age of 65 years old and 5 years after their last dose. R71's face sheet undated, identified he was 82 years old and admitted to the facility on 8/4/22. R71's undated immunization records, lacked documentation regarging receiving or declining of the pneumococcal vaccine(s). R71's immunization consent or refusal form dated 8/4/22, identified R71 declined the influenza and COVID vaccines but lacked evidence pneumococcal vaccine(s) were provided or refused. R81's face sheet undated, identified R81 was 87 years old and admitted to the facility on 1/6/23. R81's immunization records indicated R87 received the PPSV23 vaccine last on 9/11/19. There was no further documentation regarding pneumococcal vaccine(s) and that R81's vaccine series was completed or refused.	F 883	recommended schedule for pneumococcal immunizations completed. This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. 1. Corrective action to the resident affected: R71, R81, R83 will be offered the required Pneumococcal immunizations, or declination paperwork by 8/14/23. 2. Action as it applies to others: All residents have the ability to be affected. All residents will be reviewed and their current immunizations inputted into the PneumoRecs VaxAdvisor to determine eligibility and offered subsequent vaccination or obtain declination by 8/14/23. 3. Measures put into place to prevent further issues: All new admissions will be run through the VaxAdvisor and immunizations placed into the ACIP site. The policy and standing orders will be updated to reflect the current practice by 8/11/23. 4. How the facility will monitor: Audits will be conducted on 4 random residents weekly to ensure that appropriate Pneumococcal immunizations	

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F 883	Continued From page 34 R83's undated face sheet, identified he was 72 years old and admitted to the facility on 4/13/23. R83's immunization records indicated he received the PPSV23 last on 1/4/18. There was no further documentation regarding pneumococcal vaccine(s) and that R83's vaccine series was completed or refused. During an interview on 6/28/23 at 1:32 p.m., the infection preventionist (IP) stated she used the CDC PneumoRecs App to make sure the residents were up to date. During the interview she put the information into the app for R81 and R83 and stated it read they should receive a booster of PCV20. IP confirmed R81 and R83 did not receive or declined this booster. The IP then realized she had been using the vaccine information statement (VIS) with a date of 2/4/22, and found a more current version dated 5/12/23, with the current vaccine updates and recommendations. The IP stated it is important for her to know the most updated vaccine information so she can keep the residents current on their vaccines. The facilities Pneumococcal Vaccine for Residents policy dated 3/18/22, stated it is the policy of Benedictine Health System (BHS) communities to provide education and administration of the PPSV23 and PCV13 to the residents of the facility according to CDC recommendations.	F 883	documentation is complete and within the current CDC guidelines. These will be completed x 3 months to ensure compliance. Audits will be reviewed through quality council for continued need for audits based on compliance. DON and/or DON designee will be responsible for the compliance and audits Substantial compliance will be achieved 8/14/2023.	

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	245484	A. BUILDING **02 - 1975 EAST BUILDING** B. WING _____	**06/27/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/27/2023. At the time of this survey, Villa St. Vencent 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/04/2023

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
	245484	A. BUILDING **02 - 1975 EAST BUILDING** B. WING _____	**06/27/2023**

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K 000	Continued From page 1	K 000		

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.

Villa St Vincent was built at 4 different times. The 1975 (original) building is 1-story, does not have a basement, was determined to be Type II(000) construction and is separated from the multi-story senior apartment building (1950 building) with at least a 3-hour fire barrier. In 1988 a chapel addition was added to the south west of the original building, is 1-story, no basement, Type V (111) construction and separated with a 2-hour fire barrier. In 1993 a 1-story addition was constructed to the north east of the original

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245484	A. BUILDING **02 - 1975 EAST BUILDING** B. WING _____	**06/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ST VINCENT	**516 WALSH STREET** **CROOKSTON, MN 56716**

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K 000	Continued From page 2 building, is separated with a 2-hour fire barrier, does not have a basement and was determined to be Type II(111) construction. In 2003 a 1-story addition was constructed to the south of the original building, does not have a basement and was determined to be a Type II (000) construction and is not separated from the original building. The building is divided into 5 smoke zones with 2-hour and 1-hour fire rated barriers. The facility is protected with a complete automatic sprinkler system and also has a fire alarm system with corridor smoke detection and smoke detectors in all common areas that is monitored for automatic fire department notification. The facility has a capacity of 104 beds and had a census of 90 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.	K 321		8/4/23

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	245484	A. BUILDING **02 - 1975 EAST BUILDING** B. WING _____	**06/27/2023**

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K 321	Continued From page 3 Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3 and 7.2.1.8.1. These deficient finding could have a patterned impact on the residents within the facility. Findings include: On 06/27/2023 between 8:00am and 11:00am, it was revealed by observation that the two storage rooms in the Physical Therapy room did not have a self-closing devices. An interview with the Director of Plant Operations verified this deficient finding at the time of discovery.	K 321	We installed three self-closing door hinges to each of the two patient room doors that were being used for storage. I met with the OT/PT staff and made them aware of this.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101	K 324		8/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245484	A. BUILDING **02 - 1975 EAST BUILDING** B. WING _____	**06/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 324	Continued From page 4 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 REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and inspect the kitchen hood ventilation and fire suppression system per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3 and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility.	K 324	Our Kitchen Systems Inspection is done by Summit Fire Protection. Our Ansul system was inspected on 3.23.2023 by Shelby Williams, a technician for Summit Fire Protection. Further, our Kitchen Hood System was cleaned on 2.16.2023 by Hood Cleaners Company located in Moorhead, MN. Both companies are scheduled on rotation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245484	A. BUILDING **02 - 1975 EAST BUILDING** B. WING _____	**06/27/2023**

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K 324	Continued From page 5 Findings Include: On 06/27/2023 between 8:00am and 11:00am, it was revealed by a review of available documentation that inspection documentation for the kitchen hood ventilation and fire suppression system test was not available. The facility could not provide completed test/inspection documentation for the semi-annual (6 month) kitchen hood suppression system inspections for the last 12 months. An interview with the Director of Plant Operations verified this deficient finding at the time of discovery.	K 324		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced	K 351		8/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245484	A. BUILDING **02 - 1975 EAST BUILDING** B. WING _____	**06/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ST VINCENT	**516 WALSH STREET CROOKSTON, MN 56716**

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K 351	Continued From page 6 by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. These deficient findings could a patterned impact on the residents within the facility. Findings include: On 06/27/2023 between 8:00am and 11:00am, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in Housekeeping Storage - Room 245 and in Room 162 An interview with the Director of Plant Operations verified this deficient finding at the time of discovery.	K 351	There were two areas that had items stored within 18” of the ceiling. They were removed to be compliant and training of staff was done. The areas of concern have a line marked at 18” with “do not stack” above this line.	
K 353 SS=F	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.	K 353		8/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245484	A. BUILDING **02 - 1975 EAST BUILDING** B. WING _____	**06/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 353	Continued From page 7 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 REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code Section 19.7.6, and 4.6.12, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/27/2023 between 8:00am and 11:00am, it was revealed by a review of available documentation the facility failed to perform the first quarter sprinkler system testing. An interview with the Director of Plant Operations verified this deficient finding at the time of discovery.	K 353	Our sprinkler systems, both the wet system and the dry system were inspected by Summit Fie Protection on 2.02,2023.	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction	K 372		8/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245484	A. BUILDING **02 - 1975 EAST BUILDING** B. WING _____	**06/27/2023**

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K 372	Continued From page 8 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 observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 06/27/2023 between 8:00am and 11:00am, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors at Station 240 An interview with the Director of Plant Operations verified this deficient finding at the time of discovery. *NOTE* this penitration was repaired while survey team was on site - 06/27/2023 *	K 372	This was caulked with appropriate fire rated caulking during the inspection and verified by the Fire Marshal. I have provided training to the Maintenance Technician's and Maintenance Volunteer on 6.30.2023. If we have a contractor or if we run cable in the ceiling, the Maintenance Department will verify the appropriate caulking was used.	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101	K 511		8/4/23

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K 511	Continued From page 9 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3 and failed to maintain the Gas and Utility System per NFPA 101 (2012 edition), Life Safety Code section 9.2.2 and NFPA 54 (2012 edition), National Fuel Gas Code, sections 9.2.2 and 10.3.2.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/27/2023 between 8:00am and 11:00am it was revealed by observation that the electrical panel located in the link was not locked in the following locations 1) Electrical Room #2 2) Electrical Room #3 3) Outside Serving Kitchen - Panel L6 An interview with the Director of Plant Operations verified this deficient finding at the time of discovery.	K 511	The Electrical Rooms all have keypad entry locks installed on them. Panel L6 was locked. Training was provided to the Maintenance staff on 6.30.2023.	

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K 918	Continued From page 10	K 918		
K 918 SS=F	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. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 918		8/4/23

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K 918	Continued From page 11 Based on a review of available documentation and staff interview, the facility failed to install generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.1.1.16.2 and 6.4.1.1.17, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 5.6.5.2, 5.6.5, 5.6.5.6, 5.6.5.6.1, and 5.6.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/27/2023 between 8:00am and 11:00am, it was revealed by a review of available documentation of the emergency generator maintenance and testing, that documentation for the annual generator inspection could not be provided. An interview with the Director of Plant Operations verified this deficient finding at the time of discovery.	K 918	We have a signed contract with Ziegler Power Systems to conduct our; Maintenance, Preventative Maintenance and Inspections on our generators on a; Quarterly, Semi Annually and Annual basis. They also conduct full load bank (4-hour) tests to meet the requirement and be compliant. We have went over the formula to verify that we are running at, at least a 30% capacity. Our full load amps are 528 amps and 226 amps. Our generators run at 210 Amps which is well above the 162 Amps and 68 Amps needed to meet the 30% criteria. This is based on the manufactures guidelines and the technician's instruction. The Maintenance Supervisor will enter this task into our Direct Supply TELS App so it is scheduled on a re-occurring basis. An organized binder has been created to hold the necessary documentation to verify this plan and will be audited on a monthly basis by the Maintenance Supervisor.	