



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

June 25, 2026

Administrator
Villa St Vincent
516 WALSH STREET
CROOKSTON, MN 56716

RE: CCN: 177240600

Cycle Start Date: June 4, 2026

Dear Administrator:

On June 4, 2026, 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On June 2, 2026, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 11, 2026.

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

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 11, 2026, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 11, 2026, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 4, 2026. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70

Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Villa St. Vincent is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 4, 2026. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/ or "E" tag), i.e., the plan of correction should be directed to:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
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

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 4, 2026 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own

expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution

process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

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

Feel free to contact me if you have questions.

Sincerely,



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

Office: 651-201-4112



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Electronically delivered
June 25, 2026

Administrator
Villa St Vincent
516 WALSH STREET
CROOKSTON, MN 56716

Re: State Nursing Home Licensing Orders
Event ID: 231C34-H1

Dear Administrator:

The above facility survey was completed on June 4, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the

correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245484		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
NAME OF PROVIDER OR SUPPLIER Villa St Vincent				STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALSH STREET , CROOKSTON, Minnesota, 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
E0000	Initial Comments On 6/1/26 through 6/4/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			E0000			06/25/2026
F0000	INITIAL COMMENTS On 6/1/26 to 6/4/26, a standard recertification survey (S5484041-0) was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The survey resulted in an Immediate Jeopardy (IJ) at F600 when the facility failed to protect residents' rights to be free from sexual abuse by failing to complete a comprehensive assessment for capacity to consent to sexual activity for 2 of 2 residents (R58, R61) with cognitive impairment who engaged in sexual activity. In addition, the facility failed to investigate unexplained bruising and vaginal bleeding for 1 of 1 resident (R58) in the context of known sexual activity. These failures resulted in an Immediate Jeopardy (IJ) as the facility did not determine whether either resident possessed the capacity to knowingly and voluntarily consent to sexual activity, creating a likelihood that one or both residents were subjected to non-consensual sexual contact and placing them at risk for serious harm, impairment, or injury. The IJ began on 10/3/25, and the immediacy was removed on 6/2/26. The above findings constituted substandard quality of care, and an extended survey was conducted from 6/3/26 to 6/4/26.			F0000			06/25/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245484		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	Continued from page 1			F0000			06/25/2026
F0600 SS = SQC-J	The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.			F0600	Facility timely submits this response and plan of correction pursuant to federal and state law requirements and as a means to continuously promote and improve quality of care. This response and plan of correction are not admissions or an agreement that a deficiency exists or that the statement of deficiency was correctly cited or factually based, and it is also not to be construed as an admission against interest of the facility, the administrator or any employees, agents or other individuals who participated in the drafting or who may be discussed or otherwise identified in the same.		07/09/2026
	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.						
	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to protect residents' rights to be free from sexual abuse by failing to complete a comprehensive assessment for capacity to consent to sexual activity for 2 of 2 residents (R58, R61) with cognitive impairment who engaged in sexual activity. In addition, the facility failed to investigate unexplained bruising and vaginal bleeding for 1 of 1 resident (R58) in the context of known sexual activity. These failures resulted in an Immediate Jeopardy (IJ) as the facility did not determine whether either resident possessed the capacity to knowingly and voluntarily consent to sexual activity, creating a likelihood that one or both residents were subjected to non-consensual sexual contact and				In response to the above stated citation Facility has taken the following action(s): Immediately upon issuance of the IJ, R58 and R61 were separated and provided supervision to prevent further unsupervised intimate contact pending further assessment. Both residents received additional comprehensive nursing assessments, including physical and psychosocial evaluations and monitoring. Identified concerns were assessed, documented, monitored, and addressed according to physician orders and facility protocol. The attending physician, resident representatives were notified. Care plans were updated to reflect the current interventions in place for monitoring and safety of both residents. The facility has already initiated an interdisciplinary review of each resident's ability to understand, consent to, and participate in intimate relationships. Comprehensive capacity and consent evaluations completed by qualified professionals. Both residents were evaluated by their psychiatric provider on June		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245484		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
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F0600 SS = SQC-J	Continued from page 2 placing them at risk for serious harm, impairment, or injury. The immediate jeopardy began on 10/3/25 when the facility became aware of sexual activity between two residents with cognitive impairment and failed to immediately determine whether either resident possessed the capacity to consent or implement measures necessary to protect the residents from the likelihood of non-consensual sexual contact. Despite knowledge that sexual activity was occurring, the facility allowed continued unrestricted access between the residents and facilitated privacy for the relationship without first determining whether either resident possessed the capacity to consent to sexual activity. In addition, the facility failed to investigate unexplained bruising and vaginal bleeding in the context of known sexual activity, preventing the facility from determining whether the injuries were related to abuse, coercion, trauma, or other adverse outcomes associated with the relationship. Further, R58 and R61 had rooms next to each other farthest away from the nursing station, leaving more opportunity for sexual activity, that could have gone unnoticed by staff and was not documented. The administrator and director of nursing (DON) were notified of the IJ on 6/2/26, at 5:30 p.m. The IJ was removed on 6/2/26, at 7:00 p.m. when the facility successfully implemented a removal plan; however, noncompliance remained at the lower scope and severity level 2 [D] isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R58: R58's annual Minimum Data Set (MDS) dated 4/16/26, identified severe cognitive impairment and R58 wandered one to three days a week. R58 required supervision with dressing and moderate assistance with grooming and bathing. R58 was independent with transfers and ambulation. Diagnoses included Alzheimer's disease, neurocognitive disorder with Lewy bodies, dementia and anxiety. R58's Brief Interview and Staff Assessment for Mental Status (BIMS) identified the following: 9/29/25, R58 scored 11[represented moderate cognitive impairment]. R58 was able to immediately report three words she was asked to remember but could not recall one of the words without cueing and unable to recall the second word at all, after a few minutes. R58 was able to correctly identify the			F0600	Continued from page 2 8, 2026. A new assessment tool and policy was developed to evaluate each resident's capacity to provide consent and participate in sexual intimacy. This assessment was most recently completed for both residents on June 25, 2026. A conference call was held with the RPA provider to audit the new assessment tool and discuss the findings. Another interdisciplinary team (IDT) meeting is scheduled during the week of July 6, 2026, to review the assessment results and each resident's most current capacity, and identify appropriate additional interventions as needed. Additionally, another evaluation of the living environment for Residents 58 and 61 was conducted. The black mesh screen was removed from Resident 58's room to clearly differentiate the two residents' rooms and support appropriate environmental boundaries. Supervision of R58 and R61 remains in place at this time. The need for continued supervision will be reevaluated based on the outcome of the interdisciplinary team (IDT) meeting and recommendations from the involved providers. Care plans were updated to include additional individualized interventions addressing supervision, monitoring, psychosocial support, resident rights, safety measures, redirection strategies, and ongoing assessment of resident interactions. All residents residing within the memory care unit and any resident with cognitive impairment have the potential to be affected. The interdisciplinary team (IDT) met again on June 29, 2026, to conduct another review of residents who: Demonstrate cognitive impairment; Have established personal relationships with other residents; Have exhibited sexually expressive behaviors; and/or Have care plans addressing supervision, behavioral concerns, or resident-to-resident interactions. Residents identified as potentially being at risk will receive a comprehensive capacity and consent assessment to evaluate their ability to understand, provide consent, and participate in intimate relationships and/or contact. Assessment findings		07/09/2026

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NAME OF PROVIDER OR SUPPLIER Villa St Vincent				STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALSH STREET , CROOKSTON, Minnesota, 56716			
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F0600 SS = SQC-J	Continued from page 3 current year, the month, within five days and was unable to correctly identify what day it was. During the assessment, R58 asked about getting things done, needed a bust and a desire to drive and leave the facility. 12/10/25, identified R58 scored 5 [represented severe cognitive impairment]. R58 was able to immediately report three words she was asked to remember but was only able to recall one of the three words with cueing after a few minutes. R58 was unable to correctly identify the current day, month or year. 3/11/26, identified R58 scored 11. R58 was able to immediately report three words she was asked to remember but could not recall the words without cueing after a few minutes. R58 was able to correctly identify the current day, month and year. R58 became tearful during the assessment and stated her spouse was divorcing her but could not recall her spouse's name when asked. When R58 was shown a picture of her 50th wedding anniversary, R58 was no longer tearful and correctly stated her spouse had passed away. The social services assessment documentation noted R58 had been having hallucinations and had a recent medication increase. R58's Care Area Assessment (CAA) summary for Cognitive Loss dated 4/16/26, identified R58 had a diagnosis of dementia and had poor vision. R58's cognition had declined due to natural progression and R58 had episodes of hallucinations. R58 was followed by psychiatry, and staff would continue to monitor. R58's CAA summary for Behavioral Symptoms dated 4/16/26, identified R58 had a diagnosis of dementia and would wander and walk laps in the unit. R58 was usually easily redirected. R58 had hallucinations and staff would continue to monitor. R58's care plan dated 5/20/26, identified R58 had cognitive loss due to dementia and became confused to her surroundings at times. R58 exhibited behavior symptoms of wandering, intrusive in others space, history of hallucinations or delusions. The care plan identified R58 had developed a "relationship" with a male peer a goal identified R58 was to have supportive monitoring to ensure all social or physical interactions were safe and appropriate. Staff were directed to monitor and document any changes in R58's sleep patterns which included wandering, restless, or unusual interactions with peers. Staff were to note any behavioral changes or signs of distress. Staff were			F0600	Continued from page 3 will be reviewed by the IDT, and appropriate interventions and care plan updates will be implemented based on the outcomes. The facility will continue to monitor resident interactions, evaluate identified risks, and implement recommendations as determined through the IDT review process to promote resident safety, autonomy, and quality of life. The facility implemented an assessment along with updating the Abuse Prevention Plan to support the use and process for screening for residents who express interest in intimate relationships, demonstrate sexually expressive behaviors, or become involved in resident-to-resident relationships. The process includes: • Nursing assessment. • Social Services assessment. • Physician involvement. • Interdisciplinary Team review. • Resident representative involvement as appropriate. • Ongoing reassessment based upon changes in cognition, behaviors, or circumstances. Additional education was provided to licensed nurses, certified nursing assistants, social services staff, activities staff, and leadership by 7/9/26 regarding: • Recognition of verbal and non-verbal signs of consent and refusal. • Recognition of coercion, manipulation, distress, fear, or exploitation. • Resident rights related to relationships and dignity. • Reporting requirements. • Documentation expectations. • Use of the facility's assessment tool and review of the updated facility policy and procedure on the Abuse Prevention Plan. • Immediate interventions required when concerns		07/09/2026

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F0600 SS = SQC-J	Continued from page 4 to notify the social worker or director of nursing (DON) of any new or escalating concerns regarding the residents' interactions. Staff were to respect resident rights and provide privacy during interactions unless there were concerns about safety and updating family as appropriate. Further, R58 was a vulnerable adult and needed assistance to remain safe within the community. Approaches included observing and documenting changes in mood or behaviors that may increase R58's risk for abuse, implement interventions to minimize risk of harm to self and others if became violent or aggressive and to report, investigate any allegations or suspected abuse, neglect or exploitation. R58's progress notes 10/1/25 to 6/2/26, identified the following behavior and cognitive status concerns: On 11/19/25, R58 was wandering in and out of other resident's rooms looking for her baby. Resident was redirected and returned to her room each time. On 12/11/25, R58 appeared anxious at times and needed reassurance on what she needed to be doing at any given point. On 12/20/25, R58 wanted to talk with her physician about having another baby. On 1/24/26, R58 was noted to intermittently engage in conversation when no one else was present, while ambulating in the unit. R58 was also observed standing in the dining room and appeared to speak and gesture toward unseen stimuli. R58 started seeing dancers and their instruments. On 1/28/26, R58 requested water for her baby and gestured to a blanket rolled inside of her coat. An NA provided R58 with a sippy cup and R58 was observed pouring water from the cup into her hand and making motions toward the blanket. R58 showed no signs of distress and behaviors were consistent with R58's baseline. 1/28/26, R58 was concerned about the babies and showed staff the baby on her bed. R58 stated the baby looked just like the orphaned baby in the next room. On 2/8/26, R58 stated she and her husband were heading to the hospital to see her nephew. R58 was asked to come out to the common area and watch television. R58 stated she had to go pick up all the kids to take care of them.			F0600	Continued from page 4 regarding sexual contact arise. The facility revised its resident-to-resident interaction process to require immediate leadership review whenever concerns arise regarding capacity, consent, intimate relationships, or sexual behaviors involving residents with cognitive impairment. The Director of Nursing, Social Services Director, Administrator, or designee(s) will conduct audits to verify: • Capacity and consent screenings are completed when indicated. • Care plans accurately reflect supervision and safety interventions. • Resident-to-resident interactions are assessed and monitored. • Required notifications are completed. • Staff follow established intervention procedures. • Documentation is complete and accurate. Audits will be conducted: The facility will audit the 4 individuals identified as well as any other residents identified by IDT following the facility process. Audits will be conducted weekly x 8 weeks to verify completion of intimacy assessments as appropriate and review of intimate relationships between residents to ensure appropriate support, which may include supervision, is provided as needed. Audit results will also be provided to facility QAPI team. Results will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) program. Any identified concerns will result in immediate corrective action, additional staff education, and follow-up monitoring. Compliance as of: 7/9/26		07/09/2026

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F0600 SS = SQC-J	Continued from page 5 On 2/11/26, a nursing assistant (NA) reported R58 had walked up to the vitals machine and started taking notes on her paper and went looking for her children. R58 went to her room and fell asleep after 2:00 a.m. On 2/11/26, R58 was observed reaching for pictures hanging on the walls. R58 stated she was not sure how it was done, should she just take the pictures. R58 stated Fred told her to take the pictures but could not recall who Fred was and stated she would go back to her room and ask him. On 2/28/26, R58 was found kneeling on the floor by the exit door near her room. R58 was holding a winter jacket and stated she had to get on the floor so she could give her jacket to her daughter. R58 stated it was cold outside, and she did not want her daughter going outside without it. On 3/6/26, An NA reported R58 was very confused during bedtime cares. R58 kept reaching for something on the floor when there was nothing there. R58 was observed talking to the vitals machine, the bladder scanner and the mechanical lift. On 3/9/26, R58 was distraught over a project that she was left in charge of. R58 then discussed how to get the employees paid. On 3/18/26, R58 was pacing and stated she was worried people were coming to steal things. R58 was observed talking to herself as if talking with another person. R58 asked an NA if she could get into the dirty linen room to get the baby that was crying. On 3/21/26, R58 stated she thought her cross just died and asked staff to go to her room and look. Staff entered room and R58 lifted the blanket on her bed and stated well I guess it was not there. On 4/5/26, an NA reported R58 had come out of her room three to four times to look for her children. On 5/3/26, R58 was observed going into another resident's room and lying down on the bed. R58 was easily redirected. R58's progress notes 10/1/25 to 6/2/26, identified the following: On 10/3/25, R58 was found with a male resident (R61) in bed together. Both residents were not clothed and asked staff to leave them alone. Neither resident seemed uncomfortable or unhappy per the			F0600			07/09/2026

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F0600 SS = SQC-J	Continued from page 6 unidentified staff member who witnessed the incident. There were no signs of distress, coercion, or injury. The residents were provided with privacy. On 10/4/25, family member (FM)-D called and notified the facility the family wanted R58 to remain with her clothes on when in company of other residents and to sleep in her own bed every evening. After consultation with the director of nursing (DON), registered nurse (RN)-A notified the family that they understood the family's wishes, but the residents retained their right to autonomy and R58 could not be forced to comply with the family's request if it was against her wishes. The facility's plan was to continue to ensure R58's safety and dignity, while respecting her rights and preferences. On 10/9/25, scattered bruises were noted to both of R58's forearms in various stages of healing. R58 stated she occasionally bumped into things and bruised easily. On 11/19/25, an unidentified activity aide reported finding R58 in R61's bed. Both residents were undressed and in bed. When RN-A arrived at the resident's room, both residents were seated on the edge of the bed fully clothed. R58 was putting on her shoes, and when asked, agreed to return to her room. R58 was noted to be calm and cooperative with no signs of distress, however, was unsteady and complained she felt dizzy. Vital signs were obtained and were normal. FM-D was notified and requested to be called whenever those types of incidents occurred. On 12/11/25, an unidentified NA reported R58 had reported some bloody [vaginal]discharge. Staff checked toilet and room with no signs of blood. The NA assisted R58 with peri care and had not noted blood. On 3/5/26, bruising was noted on R58's right front anterior and inside of right thigh, both of which were the size of a nickel. On 5/7/26, licensed practical nurse (LPN)-A was notified by an unidentified housekeeper R58 was in bed with R61, both residents were not clothed. When LPN-A entered R61's room, both residents were standing in the R61's bathroom. R61 was just pulling up his pants and R58 was standing without pants on, and her brief was around her foot. LPN-A took R61 out of room to walk with him in the hallway and an unidentified nurse trainee assisted R58 to dress and then brought her out to the dining room.			F0600			07/09/2026

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F0600 SS = SQC-J	Continued from page 7 R58's medical record lacked evidence R58 was assessed following the first documented incident and subsequent incidents to determine her understanding and capacity to consent during each of the incidents. Further, the record lacked evidence R58 had been physically assessed following her reports of vaginal bleeding to the NA or if the bruises of unknown source had been investigated for potential cause of the injuries and if they were related to any of the sexual activity. R61: R61's quarterly MDS dated 4/24/26, identified R61 had severe cognitive impairment. No wandering, hallucinations, delusions, physical or verbal behaviors were documented. R61 was independent with all activities of daily living (ADLs) and was independent with transfer and ambulation. Diagnoses included Alzheimer's disease and dementia with psychotic disturbance, R61's BIMS assessments identified the following: 10/23/25, identified R61 scored 4 [represented severe cognitive impairment]. R61 was able to immediately report three words he was asked to remember but was only able to recall one of the words with cueing and unable to recall the other two words at all, after a few minutes. R61 was unable to correctly identify the current day, month or year, It was noted that R61 was usually pleasant with other residents. 1/22/26, identified R61 scored 4. R61 was able to immediately report three words he was asked to remember but was unable to recall any of the words after a few minutes. R61 was able to correctly identify the current day, however, was unable to identify what the current month or year was, it was noted that R61 did not wander but had a history of exit seeking. 4/24/26, identified R61 scored 3 [represented severe cognitive impairment]. R61 was able to immediately report three words he was asked to remember but was unable to recall any of the words after a few minutes. R61 was unable to correctly identify the current day, month or year, It was noted R61 stated he knew what staff were asking him and denied pain or concern and stated he loved it at the facility. R61's CAA summary for Cognitive Loss dated 1/23/26, identified R61 had a diagnosis of dementia and Alzheimer's disease. R61s cognition had declined due to natural progression but did not			F0600			07/09/2026

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F0600 SS = SQC-J	Continued from page 8 appear distressed due to not remembering. R61 was no longer agitated when asked cognitive questions and staff would continue to monitor. R61's care plan dated 5/20/26, identified R61 had cognitive loss related to dementia. A goal was listed to receive services and assistance needed to his specific level of cognitive function. Staff were directed to help keep R61 orientated and provide him with reminders as needed. R61 had behaviors of a history of wandering and checking doors. Approaches included a mesh screen to his door to deter other wanderers from entering and that R61 enjoyed visiting with others and playing guitar. The care plan identified R61 had developed a "relationship" with a female peer with a goal identified as R61 would have supportive monitoring to ensure all social or physical interactions were safe and appropriate. Staff were directed to monitor and document resident interactions and observe for signs of distress coercion, confusion or changes in behavior related to interactions with female peer. Night staff were to monitor any changes in R61's sleep patterns which included wandering, restless, or unusual interactions with peers. Staff were to note any behavioral changes or signs of distress. Staff were to notify the social worker or director of nursing (DON) of any new or escalating concerns regarding the residents' interactions. Staff were to respect resident rights and provide privacy during interactions unless there were concerns about safety and updating family as appropriate. Further, R61 was a vulnerable adult and needed assistance to remain safe within the community. Approaches included observing and document changes in mood or behaviors that may increase R61's risk for abuse, implement interventions to minimize risk of harm to self and others if became violent or aggressive and to report, investigate any allegations or suspected abuse, neglect or exploitation. R61's progress notes from 9/1/25 to 6/2/26 identified the following for behavior and cognitive concerns: On 9/29/25. R61 tried going into a female residents' room and stated he was going for a night cap. Staff redirected R61 four times, and he eventually went to a male's room to visit. On 10/3/25, R61 had several bug bites to his arms from standing outside. R61 refused to leave his shirt on when outside. On 11/1/25, R61 had flipped his mattress off the bed and stated he was looking for a part. NA reassured			F0600			07/09/2026

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F0600 SS = SQC-J	Continued from page 9 him his bed was put together correctly and did not have missing parts. R61 had a hard time communicating what he intended to say and often said he was looking for a part and then stated no that was not it while grabbing his head. On 11/16/25, R61 was given his medications and asked if he could get something to get him going. When asked what for, R61 replied, oh you know what for and winked. On 5/12/26, another resident kept telling R61 that supper was at 6:00 p.m. R61 became upset and told him to shut up and stated to staff if the resident did not shut up R61 was going to punch him. R61's progress notes from 9/29/25 to 6/2/26, identified the following: 9/29/25, R61 attempted to enter R58's room and stated he was going for a nightcap. Staff redirected R61 away from R58's room four times before R61 left to visit with another male resident. 10/3/25, R61 was found with another resident in his bed. Both residents were unclothed. R61 requested staff leave as soon as they entered the room. Both residents appeared to be enjoying each other's company. No signs of coercion or distress were noted. The residents' contact had been notified. 10/4/25, R61 brought an unidentified female resident to his room for "a night cap." The female resident looked confused/worried, so staff redirected residents with no issues. 11/19/25, an unidentified aide reported R61 and R58 were in bed undressed. When RN-A entered resident room, both residents were seated at the edge of the bed and fully clothed. R61 was observed putting on his shoes. R61 appeared calm and cooperative and displayed no signs of distress. R61 was alert and responsive and did not verbalize any discomfort or concerns. R61 stated he wished to remain in his room. Based on direct observations at the time of assessment, the interaction between R61 and R58 appeared consensual. R61's emergency contact was notified. 11/21/25, LPN-B was notified by an unidentified trained medication assistant (TMA) that R61 and R58 were in R58's room together. LPN-B checked on residents and redirected R61 back to his own room. Later, R61 was seen with R58 holding hands and touching her buttocks. After a few laps around the secured unit, the two residents entered R58's room.			F0600			07/09/2026

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F0600 SS = SQC-J	Continued from page 10 Staff were unable to redirect them. LPN-A was called to assist staff with redirection. 12/26/25, R61 entered female resident room and was attempting to get around the bed to reach the blinds. Staff reminded R61 they would help the female resident. R61 asked what was wrong with him helping her, R61 was redirected back to his room. 5/7/26, LPN-A was notified by an unidentified housekeeper R61 was in R58's room and both were lying in bed without clothing on. LPN-A entered R58's room and both residents were standing in the bathroom. R61 was just pulling up his pants and had t-shirt and socks on. R61 returned to his room with LPN-A and stated he was good. No concerns were noted. Another staff member stayed to help R58. R61's medical record lacked evidence that R58 was assessed following the first documented incident and subsequent incidents to determine his understanding and capacity to consent during each of the incidents. On 6/3/26, at 4:09 p.m. R58 was observed fully dressed, seated in a recliner in her room. R58's room was located on the secured unit furthest down the hall from the nurse's station. R61's room was located directly next to R58's room. Both rooms had a double panel of magnetic mosquito netting over the doorway on the outside of the doors. No other rooms on the secured unit had magnetic netting over their doorways. R58 stated she was unable to think of her neighbor's name or the name of the town in which she resided. R58 stated she had met a lot of people and did have friends here, but it was years ago. R58 was unable to form full sentences in response to any general questions. R58 stood up and walked out into the hallway. R58 pointed to R61's room and stated that it was her room. R58 stated she was going to go back to her room and ambulated a short distance away from her room before stopping and looking around. R58 turned back and ambulated to her own room and recliner. During interview on 6/2/26, at 8:16 a.m. housekeeper (HSK)-A stated she had entered R58's room on 5/7/26, saw that R61 was on top of R58 in bed and they were both naked. She saw that he was on top of her and did not really pay attention to her and just went out of the room to find help. She had been told that it had happened a lot, but that was the only time she had seen it. She reported it to the first nursing staff she found, which was LPN-A and LPN-A went to talk to the residents.			F0600			07/09/2026

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F0600 SS = SQC-J	Continued from page 11 When interviewed on 6/2/26, at 8:21 a.m. NA-B stated she knew R61 and R58 would go into either room, in the past the facility said that was ok. NA-B stated lately they had been told to separate them. NA-B had never witnessed any incidents. The two residents used to sit together in the dining room for meals but now they separated them to different tables. NA-B was unsure why it changed or when it changed and why they were separated in the dining room for meals. When interviewed on 6/2/26, at 8:29 a.m. NA-C stated he had heard of the incidents that had occurred but had never witnessed any. NA-C stated they had just been told they would go into each other's rooms occasionally and to redirect them if possible and let the nurse know. During interview on 6/2/26, at 8:30 p.m. LPN-C stated she was aware there had been some inappropriate behaviors and was told to just keep an eye on both. Typically staff just tried to keep the two residents apart or to make sure they were not alone. R61 was good about knowing where his room was. R58 usually knew where her room was but there had been times when she would ask where her room was and have to be directed. When interviewed on 6/2/26, at 10:11 a.m. RN-A stated R58 and R61 had interactions in the past, but they were sporadic in nature. RN-A did not know who found the two residents together on 5/7/26 as she had only talked to the nurse that had been notified. LPN-A was the nurse that had been first notified of the incident and did the follow up. The plan going forward was the same as the other incidents that had occurred, try to preserve the resident's autonomy to make their own decisions while at the same time maintaining safety for both the residents. RN-A did not know if there were any investigation or assessments completed after the incidents. Regarding the first documented incident on 10/3/25, RN-A stated she had done an assessment of R58's overall status, such as if any harm occurred, although she had not documented the assessment, as it was and informal assessment. RN-A had just checked on R58 to make sure she was not frightened RN-A had spoken with R58's FM-D to discuss the families wishes and understanding of the relationship. The family wanted R58 to remain with her clothing on and to sleep in her own bed every night. The consensus was that the residents had the right to their autonomy, give them privacy while attempting to honor the family wishes. RN-A thought the R58's bruises that were documented on 10/9/25 were in relationship to a fall			F0600			07/09/2026

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F0600 SS = SQC-J	Continued from page 12 she had at around that time. R58 had told her she bumped into things frequently and bruised easily. RN-A stated she should have followed up more, related to the bruises, but at the time had just accepted R58's explanation. RN-A was unsure if R58's physician had been notified of the report of vaginal bleeding and the bruises on her thigh on 3/5/26, were attributed to a recent fall. RN-A thought R58's physician (MD)-C was notified of the incidents at some point as it was important to notify the MD when resident interactions occurred. RN-A thought she had talked to R58 at the level of her disease and mental capacity, to see if she felt any fear. When this had been addressed, R58 had been able to recall the incidents and had reported that she had made love, but she would have to look back in the medical record to see if there was any documentation of her discussion with R58, no documentation was found. When interviewed on 6/2/26, at 11:00 a.m. LPN-A stated HSK-A had approached her on 5/7/26, when she was giving a new employee a tour and notified her the two residents were in bed together without any clothing on. So, they knocked on R58's door and was told ok to enter. R58 and R61 were in the bathroom and R61 was just pulling his pants up. R58 did not have pants on, and her brief was wrapped around one of her feet. The new employee took R58 by hand and assisted her to redress and LPN-A took R61 to his room, which was right next door. R61 stated he was fine, and the new employee told her R58 had said she was fine as well. LPN-A did not do any type of assessment with either of the residents and reported the incident to the unit manager and documented the incident in each resident's medical record. LPN-A did not fill out any type of incident report. She had been told the family was aware of the relationship and were ok with it. During telephone interview on 6/2/26, at 11:40 a.m. MD-C stated she was R58's primary care provider and the medical director for the facility. MD-C had never been notified of any sexual interactions between R58 and R61. It was very much news to her and very alarming. R58 was pleasant, however, was not orientated. R58 would likely respond to questions with a smile and ok. She has always been that way and would always be agreeable and pleasant. When MD-C last saw R58, she seemed less happy than her usual self, her affect seemed more blunted when she was seen on 5/12/26, a week after the last resident to resident incident. MD-C did not feel R58 would be able to consent in any way and had concerns with R58's ability to consent. The facility usually faxed information to her if they were			F0600			07/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245484		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
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F0600 SS = SQC-J	Continued from page 13 aware of it but she had looked back in R58's record and there was no notification documented. The last time she saw R58 the only mention was of a fall that had occurred. During interview on 6/2/26, at 11:57 a.m. the DON stated she was aware of the incidents of the residents being in an intimate position. Staff informed her of the October incident, and she had directed the staff to make sure both residents were consenting and to notify the families to let them know what was occurring. The staff knew the residents were consenting by their actions. If R58 did not want or like the interaction, she would push him away or tell him to get out. R58 was physically and verbally able to demonstrate when she was not comfortable with a situation. She is not sure if R58 had ever been asked if she knew the male resident or knew the risk or benefits of the incidents. The DON knew there had been comments made to R58 such as that is not your husband and R58 would get agitated or frustrated by the comment like she felt they were demeaning her and would respond she knew that. The DON did not know when that conversation had happened but knew a discussion had taken place after each incident, however she was not sure if any specific assessment had been completed. The DON was not aware of any type of assessment that could be used for a situation such as that. The facility had monitored the residents to make sure they were not uncomfortable with the situation. In the past, R58 had an altercation with another female resident on the secured unit and had been very verbal that she did not like that resident and would tell staff she did not want that resident in her room. The DON stated she felt R58 would react the same way with R61 if she was uncomfortable with the incidents. The interdisciplinary team (IDT) discussed the interactions each time they occurred and how the residents were at the time, prior and after each incident. Staff were able to document there were no signs of discomfort or fear. It was the DON's understanding that if the resident was able to demonstrate they did or did not want something to happen the facility would honor that. The DON did not have any documentation that staff had conversations with R58 that she denied feeling coerced and that she knew R61 was not her spouse. The DON was not aware that the resident primary physicians and psychiatric providers had not been notified of the incidents when they occurred, she would have expected the RN to have notified them both. The DON had not been aware of R58 bruises that were documented on 10/9/25 and 3/5/26. The DON was not aware that bloody vaginal discharge had been reported, and she would have expected			F0600			07/09/2026

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F0600 SS = SQC-J	Continued from page 14 R58 would have been assessed and physician notification as bloody vaginal discharge would not be normal for a resident of R58's age. During telephone interview on 6/2/26, at 12:50 p.m. FM-A stated she had been told by the facility R58 had an interest in a male resident who also resided on the secure unit. FM-A had told the facility that she wanted R58 to be safe. FM-A was concerned with issues regarding balance, transferring in and out of bed and falls as well as spending time alone in a male resident's room as safety issues. FM-A initially told the facility that she did not want R58 to have any interactions with the male resident but had been told it was R58's right and R58 was able to make those decisions on her own. The staff were doing their best and trying to navigate the situation as best as they could, but FM-A was uncomfortable with it. FM-A stated R58 was able to communicate if she was hurting or if something did not feel good, but she was not sure if R58 had the ability to give consent. There are times FM-A would get phone calls and ask if R58 should take the flu shot and FM-A gave permission for that. Prior to having Alzheimer's, incidents of that nature would have been very upsetting to R58, and FM-A did share that information with the facility staff. FM-A did not know if R58 had the capacity to say if she wanted or did not want the gentleman to enter her bed. Nighttime could be a confusing time for R58. R61 was a nice, friendly man and FM-A knew they were friends. FM-A did not think R58 mistook him for her spouse. During interview on 6/2/26, at 2:30 p.m. RN-A stated she had been told the residents had the right to consent and follow up was only needed if injury was noted. Both residents had dementia and their capacity to consent may be on different levels. If the residents were able to verbalize or demonstrate no, get away from them, then they were able to process in their head whether they want to give consent or not. R58 and R61 were able to tell her if they do not want to do something or want to refuse the attention. R58 could not sign for medical treatments. The facility called on family to consent to any medical treatment or appointments and did not ask R58 for their consent. Some days R58 was more aware and verbal with the staff and usually was pretty good at communicating. The staff judged is she was consenting by the way she communicated with them and how she responded to the situation. RN-A stated the reported vaginal bleeding had never been confirmed to have happened, it had only been reported by R58, and staff had not actually saw any bleeding. RN-A stated it depended on the day if R61 was able to give consent to sexual activity. RN-A			F0600			07/09/2026

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F0600 SS = SQC-J	Continued from page 15 stated she had been following direction and was told that both residents had the ability to consent. The last time RN-A spoke with R61's contact person, he was not overly keen on the idea but understood and basically told the staff to do what they could do. RN-A did not remember if there had been any discussion about moving the resident rooms further apart. During interview on 6/2/26, at 3:40 p.m. social worker (SW)-A stated R58 and R61 were becoming friends. Staff had reported there were no signs of distress or crying when any of the incidents occurred. The facility knew they were consensual actions by the residents' actions. The residents sought each other out, not just any female or male. There was an incident SW-A had witnessed when another male resident, not R61, had touched R58's shoulder and she clearly said no to him and moved away from him. R58 can clearly say yes or no. R58's comprehension had declined and went back and forth. The staff would not be able to determine where her comprehension was at the time of the incidents unless they did a BIMS assessment, but they knew from the resident's body language. R58 was unsteady and bumped into things and could have obtained her bruises from that. During telephone interview on 6/2/26, at 4:05 p.m. psychiatry physician (MD)-E stated he had not been notified of incidents of intimacy between R58 and a male resident. He had only been told they were sharing the same space. MD-E stated R58 did not likely have the capacity to give consent to a sexual encounter. In general, the BIMS assessment itself would not be able to determine the capacity to make decisions. The capacity to make decisions could be ok, even with patients with dementia. So, the capacity to make decisions kind of fell to the family of the resident, if unable to do a specific capacity for decision making for each procedure. If a resident's BIMS was low and had a guardian or representative that participated in other treatment decisions, then they should be involved and have the capacity of making the decision for R58. A new, specific capacity to decision make assessment would be needed for every type of decision-making situation each time a new treatment or for each occurrence. The assessment to determine the capacity for decision making would never be the same assessment as it differed depending on the treatment or type of decision that was to be made. MD-E reviewed his notes for R58 and stated he was never notified of any intimate incidents. During interview on 6/3/26, at 2:32 p.m. physician			F0600			07/09/2026

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F0600 SS = SQC-J	Continued from page 16 (MD)-G stated he was R61's primary physician. MD-G stated he had never been notified of intimate occurrences between R61 and R58 and was just learning about it for the first time. The facility had given him an assessment tool, that day [6/3/26], to review and had told him there had been multiple incidents. MD-G was not aware of how often the incidents occurred or when it had first started and was surprised the incidents had been occurring since October 2025. MD-G felt a psychiatrist would need to evaluate the residents to make sure the residents were not delusional, and behaviors were not due to underlying illness that made them more vulnerable. R61 had been stable for a few years, and the intimate incidents were a change in his behaviors. Dementia patients could have times of clarity and as the facility nurses stated, R61 could tell them where to go, and if R61 did not want something. In the moment, R61 appeared to understand the questions, but MD-G could go to him and ask him the same questions and R61 may not remember he was ever asked the questions. Every time the incident occurred, consent would need to be evaluated. Dementia was fluctuating and moments of clarity also fluctuated. A psychiatrist may not be able to determine if the residents could consent, but they could evaluate and make sure not in a delusional state or something underlying that was causing the behavior. The key piece is that a psychiatrist needed to first determine that R61 did not have a delusional or psychotic episode that led to the change in behaviors. The facility staff saw the residents every day and that held a lot of value. but it had to be determined each time, what R61's moment of clarity was. MD-G stated he thought the residents needed a psychiatric evaluation before any further incidents were allowed to occur. From the moment staff were aware of an incident start to occur, they would need to stop and redirect the residents until the psychiatric evaluations were completed. The facility policy Abuse Prevention Plan with review date 7/21/22, identified the facility would develop an individual abuse prevention plan for each vulnerable adult who received services in the facility. The plan would include the resident's susceptibility to abuse, risk of abusing other vulnerable adults and specific measures to be taken to minimize the risk of abuse. Resident incident reports and medical records would be routinely monitored for indicators of possible abuse. Any allegations involving abuse would be investigated whether they caused injury or harm or no injury or harm. All accidents, incidents and/or allegations of abuse would be thoroughly investigated and measures taken to identify the			F0600			07/09/2026

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F0600 SS = SQC-J	Continued from page 17 source of the abuse and to prevent future incidents. The facility would identify and interview all who might have knowledge of the incident. The focus of the investigation would be to determine the extent, cause and future preventions with thorough documentation of the investigative process. Facility staff would respond immediately to protect the resident from further abuse and to protect the integrity of the investigation, examine the alleged victim for any sign of injury, including a physical examination or psychosocial assessment as needed. Facility staff would separate the suspected perpetrator and resident pending the outcome of the investigation. According to the APA/ABA Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists copywritten 2008, identified an assessment of sexual consent capacity requires evaluation of three functional elements: (1) knowledge of the sexual activity and its risks and consequences, (2) decision-making capacity, including the ability to understand, appreciate, reason about, and express a choice regarding sexual activity consistent with the individual's values, and (3) voluntariness, including freedom from coercion, undue influence, or inducement. The handbook further emphasized consideration of cognitive functioning, psychiatric conditions, risks, personal values, and the use of clinical judgment rather than reliance on a simple screening tool or checklist. The IJ which began on 10/3/25, was removed on 6/2/26, at 7:00 p.m., when it could be verified through observation, interview and document review, the facility successfully implemented a removal plan which included one to one supervision of the two residents, and monitoring the two residents for signs of distress, fear, resistance, coercion, behavioral changes, bruising, trauma, and changes in psychosocial functioning. Staff completed full body skin assessments to ensure no new injuries were identified, and responsible parties for the two residents were notified of the concerns and new interventions. Physician notification was also completed. The residents' care plans were updated with the new interventions, and psychiatric evaluations were scheduled for both residents involved. Education was provided to the staff regarding the updated plan of care for both residents in regard to the residents' safety, monitoring, and supervision, until a further clinical psychological assessment could be conducted and further plan developed to ensure both residents safety. Interviews were conducted with direct care staff and management verified training on abuse, including			F0600			07/09/2026

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F0600 SS = SQC-J	Continued from page 18 signs and symptoms of potential abuse were completed.			F0600			07/09/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to honor a resident's right			F0550	F550 RESIDENT RIGHTS R42 was assessed by therapy for ability to navigate the outdoor space independently on 6/29/26 and his care plan was updated 7/2/26 to reflect his ability to independently access the secured courtyard. The resident and/or responsible party were informed of the assessment findings and individualized plan of care. On 6/28/29 all residents residing within the memory care unit who utilize or request access to the secured courtyard had their current assessments and care plans reviewed to ensure: Resident preferences regarding outdoor access are documented. Supervision requirements are individualized. Safety interventions are consistent with the resident's assessed needs. Resident rights are balanced with the least restrictive interventions appropriate to maintain safety. Any identified concerns will be immediately addressed through the interdisciplinary care planning process. The facility has implemented the following systemic changes: By 7/9/26 licensed nurses, social services, activities staff, and direct care staff will receive education regarding: Honoring resident preferences while balancing safety obligations. Documentation of resident requests and expressed preferences.		07/09/2026

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F0550 SS = D	Continued from page 19 to make choices regarding daily activities by implementing a blanket requirement that residents be accompanied by staff when accessing a secured outdoor courtyard, without an individualized assessment of the resident's safety, abilities, or need for supervision. This affected 1 of 2 residents reviewed for resident rights (R42), who expressed a desire to independently access the courtyard as part of his customary routine. Findings include: R42's admission MDS dated 3/29/26, identified R42 and intact cognition and was independent with most ADLs and transfers. R42 was unable to ambulate and independently used a wheelchair for mobility. R42 had not exhibited any physical, verbal behaviors toward others and no wandering had occurred during the observation period. R42 had not exhibited any hallucinations, delusions, however, did have documented rejection of care. Diagnoses included paranoid schizophrenia, dementia, congestive heart failure, above the knee amputation, delusional disorders, generalized anxiety and post-traumatic stress disorder. R42's care plan revised 4/17/26, identified R42 was a pleasant man who was able to make his needs known. R42 was private and preferred his independent activities versus group programs. R42's interests included model cars, watching movies, music and going outside. Staff were directed to offer and escort R42 outdoors for programs or pleasure as weather allowed. R42's customary routine was identified that he enjoyed watching movies, working on his model cars, older music and smaller groups, but may not be able to stay if feeling anxious. R42 also enjoyed being outside. R42 had impaired mobility related to a right above the knee amputation, however, R42 was independent with transfer and activities of daily living (ADLs). On 6/1/26, at 12:32, R42 was observed seated in his wheelchair in his room. R42 was alert and able to move his wheelchair around his room and in the hallway independently. R42 stated he was not happy because he had always been able to go outside to the locked unit's fenced and secure courtyard whenever he liked to and now, he had been told he would not be able to go outside unless he was accompanied by a staff member. R42 stated it was because another resident had fallen out in the courtyard a few weeks ago and had been injured, but that resident should never have been allowed out there on her own in the first place. R42 stated			F0550	Continued from page 19 The interdisciplinary assessment process when residents request changes involving independence or restrictions. Individualized supervision and least restrictive interventions in memory care. Updating care plans following changes in resident preferences or assessed needs. Additionally: A standardized process has been implemented requiring interdisciplinary review whenever a resident requests increased independence involving potential safety risks with appropriate referral made to therapy and/or physician for further guidance. Care plans will clearly identify supervision requirements and individualized interventions related to courtyard access. The Director of Nursing or designee will complete audits as follows: Five (5) memory care residents weekly for four (4) weeks, then Five (5) memory care residents monthly for two (2) months and PRN as needed based on continued compliance through review and analysis through QAPI. Audits will include: Resident preferences regarding outdoor access have been assessed. Appropriate interdisciplinary evaluations were completed when requests were made. Care plans accurately reflect supervision requirements. Staff are following individualized supervision		07/09/2026

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F0550 SS = D	Continued from page 20 he liked to go outside in the mornings when the weather was cooler and there was less wind but staff was not available to take him outside because they were busy with other resident cares. When the staff did take him outside, it was afternoon and hotter and he liked to sit out there alone, not with a group of people. R42 stated he had complained to the unit nurse, activities, social worker and administration but they just told him it was the rule for the unit. On 6/3/26, at 1:33 p.m. R42 was observed seated in the outside courtyard, in his wheelchair, visiting with R61. An unidentified staff member was seated nearby. The outside courtyard had a cement walkway and patio and a gazebo as well as grassy areas. The courtyard was fenced with a high fence and the gate was locked. R42 was listening to music on his phone and R61 was playing along on his guitar. The unidentified staff member stood up and notified the two residents she had other things to do, and the residents needed to return inside the facility. The two residents were observed complaining and stated they wanted to stay outside and why did they have to go in but they eventually went inside the facility with continued verbal complaints. R42 returned to his room. When interviewed on 6/2/26, at 10:38 a.m. registered nurse (RN)-A stated residents were never really allowed to go to the outside courtyard without supervision, but staff only recently started to reinforce the rule, when a resident recently fell in the outer courtyard. The outside courtyard was a closed fenced area with a locked gate. The door to the outside area was locked and could only be accessed by a staff members badge or family could take a resident outside. There had been some conversation regarding if more cognitive intact residents could be assessed to go out on their own, but she had been told that staff should be with the residents at all times. So far, no residents had been assessed to see if they could safely go out to the secured courtyard independently. Another problem was the door to come inside was locked and so the resident would not have access back into the building. During interview on 6/4/26, at 9:10 a.m. the social worker (SW)-A stated she was struggling with the issue as well. There was no call system since the facility had changed how the door operated. She had questioned if there was some type of call, they could give the resident to use outside or if the resident could just use their cell phone to call. The facility used to have a different door that they could lock but a resident outside could still get in. SW-A had			F0550	Continued from page 20 interventions. Documentation supports resident choice while maintaining safety. Audit findings will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) Committee. Trends or concerns identified will result in additional education and corrective actions until sustained compliance is achieved. The facility alleges compliance as of:7/9/26.		07/09/2026

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F0550 SS = D	Continued from page 21 brought up R42's complaint to the interdisciplinary team (IDT) and they were working on it, attempting to figure out a way more cognitively intact residents could go outside without supervision. The other problem was there was no shade. The facility had thought of putting an umbrella up but there was a concern it could blow over in the wind. On 6/4/26, at 1:44 p.m. a joint interview was conducted with the administrator and the director of nursing (DON). The DON stated the facility recently updated their locks to make the building more secure. The facility had also identified a concern with the current staff practices of allowing residents to out into the secured courtyard unsupervised. The ground was uneven and an accident risk, so the facility implemented that staff needed to be out with the residents in that area to ensure safety. It had always been that way, and staff had just gotten lax on the rule. They had not had a chance to evaluate each resident to see if they could be deemed safe to go out to the courtyard. One resident had recently fallen into the courtyard and because of that fall, it was discovered that staff were allowing resident's go to outside alone. If R42 were to wheel out there and go off the sidewalk, there was a risk he could tip his chair. The facility did not have therapy or nursing to assess how safe residents were when they were outside. The facility policy Resident Rights and Notification of Resident Rights, last reviewed 8/28/25, identified the facility acted to protect and ensure the rights of residents. Social services or designee would inform the residents of the Resident Rights at the time of admission and with changes to regulatory statute. Any time state or federal laws relating to resident rights or facility rules changed during the residents' stay, the residents would be promptly informed of the changes. The policy listed 45 resident rights which included exercise of rights, planning and implementing care, accommodation of needs, and grievances. The facility policy Chemical and Physical Restraints last reviewed 8/31/23, identified medical symptoms that warrant the use of restraints would be documented in the resident's medical record. Before a restraint was used the IDT would determine the presence of a medical symptom that required a restraint and how the restraint would treat the medical symptom, protect the resident's safety and assist the resident in attaining or maintaining their highest practicable level of physical and psychological wee-being. Alternative to the restraint and the risk benefits would be discussed with the			F0550			07/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245484		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
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F0550 SS = D	Continued from page 22 residents. For the residents to be fully informed, the IDT would explain the context of the resident's condition and circumstances, and the potential risks and benefits of options under consideration. Alternatives would be considered and discussed with the resident or resident representative.			F0550			07/09/2026
F0561 SS = D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to support a resident's expressed choice regarding smoking for 1 of 1 resident (R17) reviewed for resident choices. The facility failed to assess R17's request to smoke, evaluate options to accommodate the preference, and involve the interdisciplinary team after R17 repeatedly expressed a desire to resume smoking. Findings include:			F0561	The R17 was interviewed by Social Services and Nursing on 6/11, 6/18 & 6/23/26. regarding her current wishes related to smoking. The resident stated she does not wish to resume smoking at this time. The resident was provided education regarding smoking cessation resources and strategies to manage nicotine cravings. Additional smoking cessation materials were provided, and the resident was encouraged to notify nursing staff and/or social services of any future changes in smoking preferences, cessation goals, or support needs. The resident's care plan was reviewed and updated to reflect her current preferences, smoking cessation goals, and individualized interventions. Ongoing monitoring and routine reassessment will be conducted, with additional evaluations completed as needed based on the resident's wishes, choices, and expressed desires regarding smoking cessation. All residents have the potential to be affected by this deficient practice. On 6/29/26 the facility conducted an audit of residents currently identified as smokers, former smokers, or residents with documented tobacco use history to ensure: • Smoking preferences have been assessed. • Requests related to smoking have been documented and addressed. • Appropriate smoking assessments have been completed when indicated. • Care plans accurately reflect resident preferences and interventions. Any identified concerns were addressed immediately. The facility revised its process regarding resident smoking requests: • Any resident expressing a desire to begin, resume, discontinue, or change smoking practices will receive a smoking assessment by nursing.		07/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245484		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
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F0561 SS = D	Continued from page 23 R17's quarterly Minimum Data Set dated 5/8/26, identified R17 had moderate cognition and was able to make her needs known. R17's diagnoses included dementia, anxiety, depression and diabetes. R17's smoking risk assessment dated 1/22/26, identified R17 had a history of smoking but did not plan on smoking during the stay at the facility. R17's care plan printed on 4/25/26, failed to address R17's smoking preference. R17's progress notes identified the following: On 5/5/26 at 8:56 a.m., R17 reported to licensed social worker (LSW)-A she wanted to go outside and have a cigarette. On 5/18/26 at 9:07 a.m., R17 reported to LSW-A she missed smoking and wished she could still smoke. The facility failed to provide evidence of assessing R17 for ability to smoke safely off campus, since R17 expressed an interest in smoking. R17's care conference note dated 5/7/26 failed to identify discussions regarding R17's desire to smoke. On 6/2/26 at 10:30 a.m. R17 attended a resident council meeting held by the state agency (SA). R17 stated she wanted to smoke although she was told by staff that she couldn't. During interview on 6/2/26 at 11:12 a.m., R17 stated she had smoked for over 50 years prior to admission, was forced to quit smoking to be admitted to the nursing home and was not given the option to go off-site to smoke. During interview on 6/4/26 at 10:14 a.m., LSW-A stated all new residents were informed they could not smoke because the facility was a smoke-free campus and only two residents were "grandfathered in" and allowed to smoke. LSW-A stated R17 requested the desire to smoke on two occasions; however, LSW-A stated she had not documented follow up discussions with the interdisciplinary (IDT) team and the IDT team did not evaluate options to accommodate R17's preference. On 6/4/26 12:57 p.m., registered nurse (RN)-A stated residents with a history of smoking were assessed on admission by nursing and social			F0561	Continued from page 23 • Resident preferences regarding smoking will be documented in the medical record. • The interdisciplinary team will review requests related to smoking and determine any necessary safety considerations, supervision needs, and care planning interventions. • Residents will be educated regarding risks, benefits, smoking cessation resources, and available alternatives when appropriate. • Care plans will be updated to reflect resident preferences and interventions. Education was provided by 7/9/26 to licensed nurses, social services staff, activities staff, and department managers regarding: • Resident choice and self-determination. • Responding to resident requests and preferences. • Smoking assessment procedures. • Documentation requirements. • Care planning related to resident smoking preferences. The Director of Nursing, Social Services Director, or designee will conduct audits of residents who express a desire to begin, resume, discontinue, or modify smoking practices. Audits will verify: • Resident request was documented. • Smoking assessment was completed timely. • Resident rights and preferences were addressed. • Education was provided when indicated. • Care plans were updated when appropriate. Audits will be completed: • Weekly x 4 weeks on any residents who have a change in their desire for smoking then up to 3 residents per month x 2 months thereafter and PRN as needed based on continued compliance through review and analysis through QAPI.		07/09/2026

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F0561 SS = D	Continued from page 24 services. The nursing assessment included questions regarding the resident's smoking history, whether they planned to smoke while a resident at the facility, and if they were provided information regarding being a non-smoking facility. RN-A stated she was aware that R17 wanted to smoke although had not completed a smoking assessment since admission. The facility maintained a blanket practice prohibiting smoking by new residents and failed to conduct the individualized assessment and consideration of options required by its own policy after R17 repeatedly expressed a desire to smoke. The undated facility Non-Smoking – Tobacco Free/Smoke Free Campus policy identified residents that wished to smoke were to sign in/out of the facility and leave the property to smoke. Upon admission, residents would be evaluated/assessed for safe smoking practices and ability to smoke independently if they chose to do so when they were off campus. Based on the assessment, the residents may be provided with equipment to aid in safety (such as a smoking apron) when they chose to smoke while off campus. The assessment further identified the facility would consult with the resident and/or the resident representative for alternate assistance to use off campus smoking options.			F0561	Continued from page 24 Results will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) program. Additional education and corrective actions will be implemented as indicated. The facility alleges compliance as of: 7/9/2026		07/09/2026
F0604 SS = D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1),483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.			F0604	R17 received an elopement risk observation assessment regarding the continued use of the Wander Guard and the findings were reviewed and the care plan was updated to reflect changes The attending physician was notified of the assessment findings, and current physician orders were reviewed for continued appropriateness. The resident and/or responsible party participated in the interdisciplinary review, as appropriate. All other residents who have a wander guard in place have the ability to be affected. The Director of Nursing or designee completed a review of all residents currently utilizing Wander Guards or other electronic elopement prevention devices for continued need and or use for safety. Any resident identified without current documentation or reassessment received an immediate interdisciplinary evaluation, physician notification, and care plan revision as appropriate. The facility has implemented the following corrective actions:		07/09/2026

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F0604 SS = D	Continued from page 25 §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to monitor and reevaluate the continued need for a wander guard utilized as a means to restrict the resident from accessing the outdoors for 1 of 1 resident (R17) reviewed for restraints. The facility failed to complete a reassessment despite changes in R17's behaviors and expressed desire to independently access the outdoors, resulting in the continued use of the intervention without documentation supporting ongoing need. Findings include: R17's quarterly Minimum Data Set dated 5/8/26, identified R17 had moderate cognition, and was independent with activities of daily living. R17's diagnoses included dementia, anxiety, depression and diabetes. The assessment identified R17 used a wander/elopement alarm daily. R17's restraint/adaptive equipment assessment dated 1/22/26, identified R17 received antidepressants, antipsychotics, anxiolytics and narcotics, and recently experienced a decline in condition, although the type of decline was not included on the assessment. The assessment identified no other alternatives had been attempted prior to initiating the wander guard [device to alert staff to exiting secured areas of the building) and the wander guard was to be always utilized during all activities. The questions regarding whether the device met the definition of a physical restraint were not answered in the assessment. On 6/1/26 at 1:43 p.m., R17 was observed wearing a wander guard bracelet on her left wrist. R17 stated when she arrived at the facility staff had placed a wander guard on her wrist. R17 stated she was able to go outside although when she walked through the doors an alarm sounded, and staff came to check on			F0604	Continued from page 25 Education will be provided by 7/9/26 to nurse managers, licensed nurses, and social services staff regarding routine, quarterly, and significant change assessments to ensure the ongoing appropriateness of Wander Guard use and compliance with residents' rights to be free from unnecessary restraints. Additionally, the facility has implemented a standardized process requiring: Interdisciplinary team (IDT) review prior to initiation of a Wander Guard whenever practicable. Completion of a comprehensive assessment to identify the clinical justification for Wander Guard use and consideration of less restrictive alternatives. Scheduled quarterly reassessments and reassessments following any significant change in condition, elopement event, or change in wandering behavior. Physician review of the continued medical necessity for the Wander Guard. Documentation of assessment findings and clinical rationale supporting continued use. Immediate care plan revision following each reassessment to reflect current needs, interventions, and supervision requirements. Discontinuation of the Wander Guard when reassessment indicates the intervention is no longer clinically necessary. The Director of Nursing or designee will conduct audits as follows: Weekly for four (4) weeks: Audit five (5) residents utilizing Wander Guards or other electronic elopement prevention devices then Monthly for two (2) months: Audit five (5) residents utilizing these devices and PRN as needed based on continued compliance through review and analysis through		07/09/2026

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F0604 SS = D	Continued from page 26 her. R17 stated she did not like wearing the wander guard and wanted it removed. R17 stated the wander guard prevented her from enjoying the outdoors. Further, R17 stated she was told if she didn't go outside without a staff member eventually, she could have the wander guard removed. During interview on 6/3/26 at 4:05 p.m., nursing assistant (NA)-A stated if a resident had a wander guard and went out the doors an alarm sounded notifying staff, a resident had exited the doors. NA-A stated that when R17 first arrived around the beginning of the year, she had tried to go outdoors unattended but had not tried recently. During interview on 6/4/26, at 10:14 a.m., licensed social worker (LSW)-A stated wander guard assessments were completed on admission, quarterly, annually and with significant changes. The interdisciplinary (IDT) team met daily, Monday through Friday, and discussed residents who had wandering/elopement behaviors, the residents' safety concerns, and whether the wander guard should be continued. If the team determined a resident was at risk, social services completed an elopement risk assessment and nursing determined if a wander guard was appropriate. LSW-A stated R17 had an assessment completed on 1/22/26, however, was unable to find documentation that reassessments had been completed. LSW-A stated R17 should have been reassessed within three months of the initial assessment to determine if the wander guard was still needed. During interview on 6/4/26 at 1:23 p.m., LSW-B stated R17 had not shown a desire to leave the facility, and an elopement reassessment should have been completed at the quarterly mark, around April 2026. During interview on 6/4/26 at 1:44 p.m., the DON stated the facility policy identified that elopement risk assessments were to be completed on admission, quarterly, annually, with significant changes and as needed on an urgent basis. When a resident had elopement and/or wandering behaviors, the nurses were instructed to enter a progress note identifying the behaviors, interventions and outcomes. The DON stated residents with wander guards were encouraged to notify staff when they wanted to go outside because the alarm sounded when a resident passed a specific point and staff could turn the alarm off quickly. The DON stated R17 had an elopement risk assessment completed on admission and should have been reassessed quarterly to determine if the wander guard was still			F0604	Continued from page 26 QAPI. Audit findings will be reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee. Trends, identified concerns, or areas requiring improvement will result in additional education, corrective action, and continued monitoring until substantial compliance has been achieved. The facility alleges compliance as of: 7/9/26		07/09/2026

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F0604 SS = D	Continued from page 27 needed. The undated Elopement Alarm System policy identified the elopement alarm system is utilized to enhance safety for residents who wander or risk elopement from the facility. It is the facility policy to monitor the devices used for proper placement and for proper functioning of the door system as well as the resident signaling device. All residents determined at risk by the IDT team for wandering off units or with the potential for elopement from the facility will wear a signaling device. Assessment and consent will be completed on implementation and reviewed quarterly and with any significant change for continued need.			F0604			07/09/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to report allegations and suspicions of resident-to-resident sexual abuse to the State			F0609	R58 and R61 involved in the incident were immediately assessed by licensed nursing staff for injury and psychosocial well-being upon issuance of the immediate Jeopardy. Skin assessments were conducted for each resident R58 and R61 to ensure no additional physical alterations were present. The residents' care plans were reviewed and updated as appropriate to address supervision, safety, psychosocial needs, resident interactions, and monitoring requirements. And one on one supervision was put into place immediately on 6/2/26 to ensure the safety of both residents involved until further assessment could take place. Resident representatives and physicians were notified immediately on 6/2/26 of the prior incident and subsequent actions taken by the facility. All residents have the potential to be affected by this deficient practice. The facility conducted a review of incidents occurring within the previous 30 days at the time of the IJ issuance involving any: • Resident-to-resident altercations • Allegations of abuse, neglect, exploitation, or mistreatment • Resident injuries of unknown source • Resident-to-resident sexual interactions resulting in injury or concern The review was conducted to ensure required reporting, investigation, documentation, and follow-up actions were completed timely. There were no other additional incidents that required reporting.		07/09/2026

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F0609 SS = D	Continued from page 28 Agency for 2 of 2 residents (R58 and R61) reviewed for abuse after becoming aware that the residents, who had significant cognitive impairment, were engaging in sexual activity without a determination of their capacity to consent. The facility also failed to report potential injuries of unknown source for 1 of 2 residents (R58) who exhibited unexplained bruising and vaginal bleeding. Findings include: R58's annual Minimum Data Set (MDS) dated 4/16/26, identified severe cognitive impairment and wandered one to three days a week. R58 required supervision with dressing and moderate assistance with grooming and bathing. R58 was independent with transfers and ambulation. Diagnoses included Alzheimer's disease, neurocognitive disorder with Lewy bodies, heart disease, anxiety, and dementia. R61's quarterly MDS dated 4/24/26, identified R61 had severe cognitive impairment. No wandering, hallucinations, delusions, physical or verbal behaviors were documented. R61 was independent with all activities of daily living (ADLs) and was independent with transfer and ambulation. Diagnoses included Alzheimer's disease, dementia with psychotic disturbance, and atrial fibrillation (irregular heartbeat). R58's care plan with review date 5/20/26, identified R58 had cognitive loss due to dementia and became confused to her surroundings at times. R58 exhibited behavior symptoms of wandering, intrusive in others space, history of hallucinations or delusions. The care plan identified R58 had developed a "relationship" with a male peer a goal identified R58 was to have supportive monitoring to ensure all social or physical interactions were safe and appropriate. Staff were directed to monitor and document any changes in R58's sleep patterns which included wandering, restless, or unusual interactions with peers. Staff were to note any behavioral changes or signs of distress. Staff were to notify the social worker or director of nursing (DON) of any new or escalating concerns regarding the resident's interactions. Staff were to respect resident rights and provide privacy during interactions unless there were concerns about safety and update family as appropriate. Further, R58 was a vulnerable adult and needed assistance to remain safe within the community. Approaches included to observe and document changes in mood or behaviors that may increase R58's risk for abuse, implement interventions to minimize risk of harm to self and others if became violent or aggressive and to report, investigate any allegations or suspected			F0609	Continued from page 28 The facility reviewed and reinforced its abuse prevention and reporting process to ensure any allegation, suspicion, observation, injury of unknown source, resident-to-resident altercation, or resident-to-resident sexual interaction resulting in injury, bruising, concern, or potential abuse is immediately reported to facility leadership for evaluation and reporting determination. Education will be provided to all licensed nurses, certified nursing assistants, social services staff, department managers, and leadership by 7/9/2026. • F609 reporting requirements • Definitions of abuse, neglect, exploitation, and injuries of unknown source • Reporting timelines and requirements • Resident-to-resident incidents and potential abuse concerns • Documentation expectations • Immediate protective interventions • Notification requirements for administration and state agencies • Investigation procedures Leadership review of all incident reports was implemented to ensure timely reporting determinations and follow-up actions. The Administrator, Director of Nursing, Social Services Director, or designee will audit incident reports to verify: • Incidents were reported timely to facility leadership. • Required state agency reporting occurred when indicated. • Investigations were initiated timely. • Resident and representative notifications were completed. • Protective interventions were implemented. • Documentation was complete and accurate. Audits will be completed:		07/09/2026

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F0609 SS = D	Continued from page 29 abuse, neglect or exploitation. R58's medical record lacked an assessment identifying the resident had the capacity to consent to a sexual relationship. R61's care plan with review date 5/20/26, identified R61 had cognitive loss related to dementia. A goal was listed to receive services and assistance needed to his specific level of cognitive function. Staff were directed to help keep R61 orientated and provide him with reminders as needed. R61 had behaviors of a history of wandering and checking doors. Approaches included a mesh screen to his door to deter other wanderers from entering and that R61 enjoyed visiting with others and playing guitar. The care plan identified R61 had developed a "relationship" with a female peer with a goal identified as R61 would have supportive monitoring to ensure all social or physical interactions were safe and appropriate. Staff were directed to monitor and document resident interactions and observe for signs of distress coercion, confusion or changes in behavior related to interactions with female peer. Night staff were to monitor for any changes in R61's sleep patterns which included wandering, restless, or unusual interactions with peers. Staff were to note any behavioral changes or signs of distress. Staff were to notify the social worker or director of nursing (DON) of any new or escalating concerns regarding the resident's interactions. Staff were to respect resident rights and provide privacy during interactions unless there were concerns about safety and update family as appropriate. Further, R61 was a vulnerable adult and needed assistance to remain safe within the community. Approaches included to observe and document changes in mood or behaviors that may increase R61's risk for abuse, implement interventions to minimize risk of harm to self and others if became violent or aggressive and to report, investigate any allegations or suspected abuse, neglect or exploitation. R61's medical record lacked an assessment identifying the resident had the capacity to consent to a sexual relationship. R58's progress notes 10/1/25 to 6/2/26, identified the following: 10/3/25, R58 was found with a male resident (R61) in bed together. Both residents were not clothed and asked staff to leave them alone. The residents were provided privacy. 10/9/25, scattered bruises were noted to both of			F0609	Continued from page 29 • 5 times a week of any reported incidents involving potential abuse x 2 months and PRN as needed based on continued compliance through review and analysis through QAPI. Results will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) program. Trends, concerns, and opportunities for improvement will be addressed through additional education and corrective actions as indicated. The facility alleges compliance as of: 7/9/26.		07/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245484		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
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F0609 SS = D	Continued from page 30 R58's forearms in various stages of healing. R58 stated she occasionally bumped into things and bruised easily. 11/19/25, an unidentified activity aide reported finding R58 in R61's bed. Both residents were undressed and in bed. 12/11/25, an unidentified nursing assistant (NA) reported R58 had reported some bloody discharge. Staff checked toilet and room with no signs of blood. The NA assisted R58 with peri care and had not noted blood. There was no further documentation. 3/5/26, bruising was noted on R58's right front anterior and inside of right thigh, both of which were the size of a nickel. 5/7/26, licensed practical nurse (LPN)-A was notified by an unidentified housekeeper R58 was in bed with R61, both residents were not clothed. R61's progress notes 9/20/25 to 6/2/26, identified the following: 10/3/25, R61 was found with another resident in his bed. Both residents were unclothed. 11/19/25, an unidentified aide reported R61 and R58 were in bed undressed. 5/7/26, LPN-A was notified by an unidentified housekeeper R61 was in R58's room and both were lying in bed without clothing on. During interview on 6/2/26, at 11:01 a.m. LPN-A stated she had documented the incident in each of the resident's medical records and reported the incident to the unit manager RN-A. She did not fill out an event report, just documented in the resident progress notes because she had been told the family were aware of the incidents and were ok with them. When interviewed on 6/2/26, at 2:30 p.m. registered nurse (RN)-A stated regarding the first documented incident on 10/3/25, RN-A stated she had done an assessment of R58's overall status, such as if any harm. Regarding filing a Vulnerable Adult (VA) report, she would have to look at the policy, but her understanding was if there were incidents of coercion, or concerns with safety, such as physical harm, slapping, biting hitting, she would elevate the concerns to the director of nursing (DON) or the administrator. She had been told in these incidences, was that the resident's had a right to consent and follow up would only be needed if there			F0609			07/09/2026

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F0609 SS = D	Continued from page 31 were injury. RN-A had never filed a VA report herself but had discussed the incidents with the team for guidance. RN-A stated with bruises of unknown origin, staff were to notify the physician and fill out an event report. RN-A had documented R58's bruised forearms on 10/9/25. R58 had stated she bumped into things, RN-A took her word for it, but thought now she should have followed up more on it. It was not assessed in relation to the sexual relationship. During interview on 6/2/25, at 11:57 a.m., the DON stated the facility had not reported the intimate incidents that had occurred between R58 and R61 because, when discussed with the facility interdisciplinary team (IDT), it was felt the incidents were consensual in nature and not abuse. The DON stated she was not aware of the bruises on R58's forearms, documented 10/9/25. It was the facility's process that bruises of unknown origin were reported to the state agency. When bruises of unknown injury were reported an incident report was filled and a vulnerable adult (VA) report was completed. When interviewed on 6/2/25, at 3:40 p.m. the social worker (SW)-A stated the incidents between the residents were not reportable as the resident's had a right to intimacy. As far as R58's bruises, R58 was unsteady and bumped into things. The bruises would be for nursing to evaluate. SW-A stated she was not involved in VA reports any longer. She used to be but now submission of VA reports fell to nursing and the DON, as they were the ones completing the investigations. Bruises would need to be reported if there were no explanation for them or no other way they could have occurred other than abuse. SW-A did not get notified of incidents and/or injuries any longer. Those sorts of reports went to the DON. SW-A was more involved in the financial side of things and if any nursing issues, would go to the DON. It was usually determined by the DON or unit manager if an incident needed follow up or further investigation. During joint interview with the administrator, corporate RN (CP)-F and the DON on 6/2/26, at 5:00 p.m., the DON stated based on the resident's mood and behaviors, it was felt the incidents were consensual and not abuse and so the facility decided not to report the incidents to the state agency (SA). R58's bruises had never been reported because she walked around holding on to her arms, bumped into things and was on aspirin, so the facility staff came to the conclusion that was the cause. The facility's policy was to report bruises of			F0609			07/09/2026

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F0609 SS = D	Continued from page 32 unknown origin, fill out an incident report and complete a VA report. The DON was not sure if she had been notified of the bruises found on R58's inner thigh. The facility policy Abuse Prevention Plan with review date 7/21/22, identified the facility would develop an individual abuse prevention plan for each vulnerable adult who received services in the facility. The plan would include the resident's susceptibility to abuse, risk of abusing other vulnerable adults and specific measures to be taken to minimize the risk of abuse. Resident incident reports and medical records would be routinely monitored for indicators of possible abuse. Any allegations involving abuse would be investigated whether they caused injury or harm or no injury or harm. Staff would notify the facility administrator, DON and director of social services. If the event involved abuse or resulted in serious bodily injury, staff were required to report to the SA immediately, but no later than two hours after forming the suspicion. If the event did not involve abuse and did not result in bodily injury, staff were required to report to the SA no later than 24 hours after forming the suspicion.		F0609				
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to investigate potential resident-to-resident		F0610	Immediately upon identification of the concern, both residents, R58 and R61 were separated and provided supervision to ensure their immediate safety while the investigation was completed. Each resident received: A comprehensive nursing assessment, including a head-to-toe skin assessment. Assessment and documentation of all bruising, injuries, and areas of concern. Immediate physician notification. Notification of each resident's responsible party/representative. Individual psychosocial assessment daily A comprehensive interdisciplinary evaluation of each resident's capacity to consent to sexual activity using the facility's established assessment tool, with physician consultation and additional specialty		07/09/2026	

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F0610 SS = D	Continued from page 33 sexual abuse for 2 of 2 residents (R58, R61) reviewed for abuse. The facility became aware of repeated sexual activity between two residents with significant cognitive impairment but failed to assess either resident's capacity to consent to sexual activity. As a result, the facility was unable to determine whether the encounters were consensual and failed to complete a thorough abuse investigation. Additionally, the facility failed to investigate bruising and reports of vaginal bleeding experienced by R58 in relation to the known sexual activity. Findings include: R58 R58's annual Minimum Data Set (MDS) dated 4/16/26 identified severe cognitive impairment. Diagnoses included Alzheimer's disease, neurocognitive disorder with Lewy bodies, and dementia. R58's care plan identified cognitive loss related to dementia, confusion, wandering, hallucinations or delusions, and identified R58 as a vulnerable adult. Staff were directed to report and investigate any allegations or suspected abuse, neglect, or exploitation. R58's progress notes identified the following: On 10/3/25, R58 and R61 were found together in bed unclothed and requested privacy. On 11/19/25, staff again found R58 and R61 undressed in bed together. On 5/7/26, staff found R58 and R61 in bed together without clothing. The record failed to contain evidence the facility assessed either resident's capacity to consent to sexual activity following any of the incidents. The record further identified: On 10/9/25, scattered bruises in various stages of healing were noted on both forearms. On 12/11/25, R58 reported bloody vaginal discharge. On 3/5/26, bruising was noted to the right anterior thigh and inner thigh. The record failed to contain evidence the facility investigated whether the bruising or report of			F0610	Continued from page 33 consultation as clinically indicated. Interdisciplinary review involving nursing, social services, the attending physician, and other appropriate disciplines to determine appropriate interventions. Each resident's care plan was revised to include individualized supervision, safety interventions, monitoring, psychosocial support, and interventions based on the investigation findings and assessment outcomes. The Director of Nursing or designee reviewed all residents residing within the memory care unit and any other residents identified as having intimate relationships or behaviors placing them at risk for exploitation. The review included verification that: Residents demonstrating sexually expressive behaviors have individualized assessments. Capacity to consent has been evaluated when indicated. Appropriate supervision interventions are implemented. Care plans accurately reflect resident needs. Appropriate abuse prevention interventions are in place. Residents identified without current assessments or individualized interventions received immediate interdisciplinary review, care plan updates, and implementation of appropriate safety measures. The facility has implemented the following corrective actions: Education will be provided by 7/9/26 to all licensed nurses, certified nursing assistants, social services staff, activities staff, therapy staff, department managers, and leadership regarding:		07/09/2026

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F0610 SS = D	Continued from page 34 vaginal bleeding were related to the known sexual activity involving R58 and R61. R61 R61's quarterly MDS dated 4/24/26 identified severe cognitive impairment. Diagnoses included Alzheimer's disease and dementia with psychotic disturbance. R61's care plan identified cognitive loss related to dementia and identified R61 as a vulnerable adult. Staff were directed to observe for signs of distress, coercion, confusion, or behavioral changes related to interactions with R58 and to report and investigate any allegations or suspected abuse, neglect, or exploitation. R61's progress notes identified staff found R58 and R61 unclothed together on 10/3/25, 11/19/25, and 5/7/26. The record failed to contain evidence the facility assessed R61's capacity to consent to sexual activity or completed an abuse investigation to determine whether the encounters were consensual. On 6/2/26 at 10:11 a.m., registered nurse (RN)-A stated she did not know if any investigation or assessments had been completed following the incidents involving R58 and R61. RN-A stated she had not documented assessments related to the incidents or the bruising identified on R58. On 6/2/26 at 11:01 a.m., licensed practical nurse (LPN)-A stated she documented the 5/7/26 incident but did not complete assessments/investigations on either resident and was unsure whether any assessments/investigations had been completed by others. On 6/2/26 at 11:57 a.m., the director of nursing (DON) stated no assessments had been conducted following the incidents to evaluate physical injury or assess the residents' judgment or capacity to consent. The DON stated the facility believed the encounters were consensual based on the residents' behaviors and no further investigation had been conducted and the facility staff knew the incidents were consensual by how the residents behaved and their actions and no further investigation had been conducted. The DON further stated the facility did not complete a formal investigation process. At 5:00 p.m., the DON stated the facility did not conduct a formal investigation because staff believed the incidents were			F0610	Continued from page 34 Identification and reporting of alleged abuse, neglect, exploitation, and injuries of unknown source. Immediate actions required when allegations of sexual contact or sexual abuse are identified. Recognition and documentation of bruising, bleeding, trauma, and physical findings. Immediate physician notification and timely medical evaluation. Conducting thorough abuse investigations. Interview techniques and documentation expectations. By Use of the facility's new assessment tool. Recognition of verbal and non-verbal signs of consent and refusal. Resident rights related to relationships, dignity, and protection from abuse. Care planning following allegations involving resident-to-resident sexual contact. Additionally, the facility has implemented the following system improvements: The new standardized assessment tool will be completed whenever resident-to-resident sexual contact is identified or suspected. Associated injuries will be documented in the medical record with assessment findings. All abuse investigations will include verification that physician notification, resident representative notification, required state reporting, interviews, evidence collection, assessments, and care plan		07/09/2026

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F0610 SS = D	Continued from page 35 consensual. The DON further stated R58's bruising had not been investigated, and she was unaware of the reports of inner thigh bruising and vaginal bleeding. The facility's Abuse Prevention Plan directed staff to investigate allegations involving abuse and to monitor incident reports and medical records for indicators of possible abuse			F0610	Continued from page 35 revisions have been completed. The Director of Nursing, Administrator, or designee will conduct audits as follows: An audit will be conducted on any and all abuse allegations x 2 months and PRN as needed based on continued compliance through review and analysis through QAPI. to verify the following: Allegations were immediately reported. Residents were protected pending investigation. Comprehensive nursing assessments were completed. Physician notifications occurred timely. Responsible parties and required agencies were notified. Injuries, bruising, bleeding, and physical findings were thoroughly documented. Capacity to consent assessments were completed when indicated. Investigations included interviews, evidence collection, witness statements, and findings. Care plans were updated based on investigation outcomes. Corrective actions were implemented and documented. Audit results will be reviewed during the facility's Quality Assurance and Performance Improvement (QAPI) Committee meetings. Trends, deficiencies, or opportunities for improvement will result in additional education, process revisions, and continued monitoring until sustained compliance is achieved.		07/09/2026

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F0610 SS = D				F0610	Continued from page 36		07/09/2026
F0883 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: (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			F0883	The facility alleges compliance as of: 7/9/26 R42 and resident representative were given the current VIS for any eligible pneumococcal vaccinations on 7/2/26. Resident was offered the vaccine again and declined. This was documented in the resident record with the current VIS edition date provided. All current residents have the ability to be affected. A current VIS for each vaccination received or declined will be provided to all residents and/or resident representatives. The resident's medical record was updated to document: • The VIS provided • VIS edition date • Date the VIS was provided The facility revised its Immunization Program process to require: • Current CDC Vaccine Information Statements will be provided to residents and/or resident representatives at the time vaccines are offered and prior to vaccine administration or refusal. • Licensed nurses will document the VIS edition date and date provided in the medical record. • The vaccination consent/refusal process was updated to include verification that the VIS was provided. • Current VIS documents will be maintained and updated by the Infection Preventionist or designee whenever CDC revisions occur. • VIS documents will be available in electronic and paper formats. • Admission packets will include current immunization education materials and VIS information when applicable. Education was provided by 6/30/26 to, Infection Preventionist • Resident education requirements		07/09/2026

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F0883 SS = D	Continued from page 37 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 provide education regarding the benefits and potential side effects of pneumococcal vaccination and failed to document that education was provided prior to obtaining a vaccination decision from the resident representative for 1 of 5 residents (R42) reviewed for immunizations. Findings included: R42's Comprehensive Minimum Data Set (MDS) dated 4/3/26, identified R42 as 64 years old, had mild cognitive impairment and diagnoses that included heart failure, peripheral vascular disease, diabetes, and dementia. R42 was offered the pneumococcal vaccination but declined. R42's Immunization Report dated 3/23/26, identified R42 received pneumovax (PPSV23) on 5/20/09, and a pneumococcal conjugate vaccine (Prevnar 13) on 5/20/09. R42's Immunization Report dated 8/30/23, identified R42 received pneumovax (type unknown) on 4/28/14, and a pneumococcal conjugate vaccine (Prevnar 13) on 9/8/16. R42's medical record did not include evidence R42 or R42's representative received education regarding pneumococcal vaccine booster and there was no indication R42 was offered the pneumococcal vaccine per CDC guidance. R42's Immunization Consent form dated 3/23/26, identified R42's son declined the pneumococcal vaccination by phone. However, the form did not include evidence R42 or R42's representative received education regarding pneumococcal vaccine booster per CDC guidance. During an interview on 6/3/26 at 10:24 a.m., RN-B stated R42's family declined the pneumococcal			F0883	Continued from page 37 • Proper use of CDC Vaccine Information Statements • Documentation requirements for vaccine offers, acceptance, and refusals • Documentation of VIS edition date and date provided The Infection Preventionist, Director of Nursing, or designee will conduct audits of resident vaccination records to verify: • Appropriate VIS was provided • VIS edition date documented • Date VIS was provided documented • Resident/resident representative decision documented Audits will be completed: • Weekly x 4 weeks on any offered, declined or administered vaccinations then monthly on up to 5 residents who have been offered, declined, administered any vaccinations and PRN as needed based on continued compliance through review and analysis through QAPI. Results will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) program. Additional education and corrective action will be implemented as indicated. The facility alleges compliance as of: 7/9/26		07/09/2026

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F0883 SS = D	Continued from page 38 vaccination by phone. Most family members didn't want to read the education, so RN-B didn't mail any education to anyone for review, nor did she document that. During an interview on 6/4/26 at 8:50 a.m., the director of nursing (DON) stated the resident and the resident representative need to be provided with all the education regarding vaccinations to ensure they understand what they are refusing or consenting to. Documentation should reflect their understanding of that education.The facility policy Pneumococcal Vaccines for Residents dated 1/9/25, identified the facility would provide education and administration of the PPSV23 and PCV13 to the residents according to CDC recommendations. CDC now recommended pneumococcal conjugate vaccine (PCV15 or PCV20) for adults who never received a prior pneumococcal conjugate vaccine (PCV13) if they are 50 years or older and have certain chronic medical conditions or other risk factors. For adults who have only received PCV13 but not PPSV23, CDC recommends vaccine providers give PPSV23 as previously recommended. The infection preventionist or designee will provide the resident and/or the responsible party		F0883			07/09/2026	
F0887 SS = D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80 Infection control §483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses,		F0887	R30 will be administered the consented covid-19 vaccine on 7/7/26. R30 will be given the opportunity to ask questions regarding the vaccine and reaffirm or decline consent after receiving the current vaccine information. R16 and R42 were provided with the current COVID-19 Vaccine Information Statement (VIS) on 7/2/26. Both residents continue to decline the COVID-19 vaccine. The resident's medical record was updated to accurately reflect: Current vaccine education provided Resident questions and responses Consent or refusal Vaccine administration, if applicable Date and manufacturer information		07/09/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245484		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/04/2026	
NAME OF PROVIDER OR SUPPLIER Villa St Vincent				STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALSH STREET , CROOKSTON, Minnesota, 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
F0887 SS = D	Continued from page 39 including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses. (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident, or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure eligible residents received COVID-19 vaccination after consent was obtained for 1 of 5 residents (R30); and the facility failed to provide current Centers for Disease Control and Prevention (CDC) COVID-19 vaccine education regarding the potential benefits and risks of vaccination to resident representatives prior to obtaining a refusal for 2 of 5 residents (R16, R42) reviewed for COVID-19 vaccination status. These failures resulted in one resident not receiving a consented-to vaccination and had the potential to affect residents' ability to make informed vaccination decisions.			F0887	Continued from page 39 Required documentation in the immunization record The attending physician and resident representative, when appropriate, were notified. The Director of Nursing or designee offered the COVID-19 vaccine to all eligible residents and obtained consent or declination. Each resident was provided with the current VIS for COVID-19. The facility implemented the following corrective actions: Education will be provided by 6/30/26 to infection preventionist CMS F887 COVID-19 immunization requirements. Current CDC recommendations regarding resident vaccine education. Requirements for providing the most current VIS, EUA Fact Sheet, or applicable vaccine information before vaccination. Documentation of informed consent or refusal. Vaccine ordering and administration procedures. Documentation requirements within the electronic medical record and immunization tracking log. Procedures for monitoring residents who consent but have not yet received the vaccine. Physician notification requirements when indicated. Additionally, the facility has implemented the following process improvements: Current CDC vaccine educational materials will be maintained and updated immediately whenever revised guidance becomes available.		07/09/2026

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F0887 SS = D	Continued from page 40 Findings include: Unadministered Vaccines R30 R30's admission Minimum Data Set (MDS) dated 2/23/26, identified R98 as 78 years old, cognitively aware and had diagnoses that included Multiple Sclerosis, congestive heart failure (CHF), Rheumatoid Arthritis, and Parkinson's disease. R30 was not up to date for COVID-19 vaccination. The MDS did not identify if R30 was offered a COVID-19 vaccination. R30's Immunization Consent form dated 2/17/26, identified R30 consented to receive the COVID-19 vaccination. R30's medical record failed to identify R30 had received the corresponding COVID-19 vaccination. During an interview on 6/3/26 at 10:21 a.m., registered nurse (RN)-B stated she was responsible for the facility's infection prevention program and the resident vaccinations. RN-B stated she was unsure why R30 had not received the COVID-19 vaccination as R30 had consented. RN-B stated the facility did not currently have any COVID-19 vaccine, however, RN-B stated when she ordered the vaccine the facility would have the COVID-19 vaccine available. RN-B usually ordered vaccines once per year in the fall. R30 consented to receive the COVID-19 vaccine on 2/17/26. Review of the medical record through 6/4/26 failed to identify the vaccine had been administered or documentation explaining why it was not administered despite approximately three, and one-half months having elapsed since consent was obtained. Education R16 R16's admission MDS dated 3/31/26, identified R16 as 91 years old, had a mild cognitive impairment and diagnoses that included CHF and atrial fibrillation (irregular heartbeat). R16 was not up to date for COVID-19 vaccination. The MDS did not identify if R16 was offered a COVID-19 vaccination. R16's Immunization Consent form dated 3/23/26, identified R16's son declined the COVID-19 vaccination by phone. However, the form failed to identify the education provided to R16's son.			F0887	Continued from page 40 Updated internal consent and declination forms to include the edition of the VIS provided The Director of Nursing, Infection Preventionist, or designee will conduct audits as follows: Weekly for four (4) weeks: Audit any residents with recent COVID-19 vaccination activity then monthly for two (2) months: Audit five (5) residents with COVID-19 vaccination activity, or all residents if fewer than five and PRN as needed based on continued compliance through review and analysis through QAPI. The audit will verify: Current VIS provided for any offered or declined COVID-19 vaccinations Timely administration of consented vaccinations for COVD-19 Audit findings will be reviewed through the facility's Quality Assurance and Performance Improvement (QAPI) Committee. Any trends or deficiencies identified will result in additional education, corrective actions, and continued monitoring until substantial compliance has been achieved. The facility alleges compliance as of: 7/9/26		07/09/2026

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F0887 SS = D	Continued from page 41 R42 R42's admission MDS dated 4/3/26, identified R42 as 64 years old, had a mild cognitive impairment and diagnoses that included heart failure, peripheral vascular disease, diabetes, and dementia. R42 was not up to date for COVID-19 vaccination. The MDS failed to identify if R42 was offered a COVID-19 vaccination. R42's Immunization Consent form dated 3/23/26, identified R42's son declined the COVID-19 vaccination by phone. However, the form failed to identify the education provided to R42's son. During an interview on 6/3/26 at 10:24 a.m., RN-B stated R16 and R42's family declined the COVID-19 by phone. Most family members didn't want to read the education, so RN-B doesn't mail any education to anyone for review, nor does she document that. During an interview on 6/4/26 at 8:50 a.m., the director of nursing (DON) stated there was no documentation in R30's medical record that reflected R30 was given the COVID-19 vaccination nor why R30 had not received it. The DON stated should have received the vaccination as R30 had consented to. The DON also stated the resident and the resident representative need to be provided with all the education regarding vaccinations to ensure they understand what they are refusing or consenting to. Documentation should reflect their understanding of that education. The facility policy COVID-19 Vaccine and Booster for Residents dated 5/11/21, identified the facility would assure all residents that are eligible are offered the COVID-19 vaccination and booster doses when available.			F0887			07/09/2026

Minnesota Department of Health

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20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/1/26 through 6/4/26, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal		20000			06/25/2026	

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

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20000	Continued from page 1 software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.		20000			06/25/2026	
20520	Use of Restraints CFR(s): MN Rule 4658.0300 Subp. 3 B Subp. 3. Emergency use of restraint. B. If a restraint is needed, a physician's order must be obtained which specifies the duration and circumstances under which the restraint is to be used. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document		20520	Completed		07/09/2026	

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20520	Continued from page 2 review, the facility failed to monitor and reevaluate the continued need for a wander guard utilized as a means to restrict the resident from accessing the outdoors for 1 of 1 resident (R17) reviewed for restraints. The facility failed to complete a reassessment despite changes in R17's behaviors and expressed desire to independently access the outdoors, resulting in the continued use of the intervention without documentation supporting ongoing need. Findings include: R17's quarterly Minimum Data Set dated 5/8/26, identified R17 had moderate cognition, and was independent with activities of daily living. R17's diagnoses included dementia, anxiety, depression and diabetes. The assessment identified R17 used a wander/elopement alarm daily. R17's restraint/adaptive equipment assessment dated 1/22/26, identified R17 received antidepressants, antipsychotics, anxiolytics and narcotics, and recently experienced a decline in condition, although the type of decline was not included on the assessment. The assessment identified no other alternatives had been attempted prior to initiating the wander guard [device to alert staff to exiting secured areas of the building) and the wander guard was to be always utilized during all activities. The questions regarding whether the device met the definition of a physical restraint were not answered in the assessment. On 6/1/26 at 1:43 p.m., R17 was observed wearing a wander guard bracelet on her left wrist. R17 stated when she arrived at the facility staff had placed a wander guard on her wrist. R17 stated she was able to go outside although when she walked through the doors an alarm sounded, and staff came to check on her. R17 stated she did not like wearing the wander guard and wanted it removed. R17 stated the wander guard prevented her from enjoying the outdoors. Further, R17 stated she was told if she didn't go outside without a staff member eventually, she could have the wander guard removed. During interview on 6/3/26 at 4:05 p.m., nursing assistant (NA)-A stated if a resident had a wander guard and went out the doors an alarm sounded notifying staff, a resident had exited the doors. NA-A stated that when R17 first arrived around the beginning of the year, she had tried to go outdoors unattended but had not tried recently. During interview on 6/4/26, at 10:14 a.m., licensed			20520			07/09/2026

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20520	Continued from page 3 social worker (LSW)-A stated wander guard assessments were completed on admission, quarterly, annually and with significant changes. The interdisciplinary (IDT) team met daily, Monday through Friday, and discussed residents who had wandering/elopement behaviors, the residents' safety concerns, and whether the wander guard should be continued. If the team determined a resident was at risk, social services completed an elopement risk assessment and nursing determined if a wander guard was appropriate. LSW-A stated R17 had an assessment completed on 1/22/26, however, was unable to find documentation that reassessments had been completed. LSW-A stated R17 should have been reassessed within three months of the initial assessment to determine if the wander guard was still needed. During interview on 6/4/26 at 1:23 p.m., LSW-B stated R17 had not shown a desire to leave the facility, and an elopement reassessment should have been completed at the quarterly mark, around April 2026. During interview on 6/4/26 at 1:44 p.m., the DON stated the facility policy identified that elopement risk assessments were to be completed on admission, quarterly, annually, with significant changes and as needed on an urgent basis. When a resident had elopement and/or wandering behaviors, the nurses were instructed to enter a progress note identifying the behaviors, interventions and outcomes. The DON stated residents with wander guards were encouraged to notify staff when they wanted to go outside because the alarm sounded when a resident passed a specific point and staff could turn the alarm off quickly. The DON stated R17 had an elopement risk assessment completed on admission and should have been reassessed quarterly to determine if the wander guard was still needed. The undated Elopement Alarm System policy identified the elopement alarm system is utilized to enhance safety for residents who wander or risk elopement from the facility. It is the facility policy to monitor the devices used for proper placement and for proper functioning of the door system as well as the resident signaling device. All residents determined at risk by the IDT team for wandering off units or with the potential for elopement from the facility will wear a signaling device. Assessment and consent will be completed on implementation and reviewed quarterly and with any significant change for continued need.			20520			07/09/2026

Minnesota Department of Health

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20520	Continued from page 4 SUGGESTED METHOD OF CORRECTION: The DON or designee could review policies and procedures and update as needed; and review residents with wander guards and reassess for their continued need, ensure assessments and care plans are up to date. Educate staff on the expectation and then audit for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20520			07/09/2026
21810	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 6 Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to honor a resident's right to make choices regarding daily activities by implementing a blanket requirement that residents be accompanied by staff when accessing a secured outdoor courtyard, without an individualized assessment of the resident's safety, abilities, or need for supervision. This affected 1 of 2 residents reviewed for resident rights (R42), who expressed a desire to independently access the courtyard as part of his customary routine. Findings include: R42's admission MDS dated 3/29/26, identified R42 and intact cognition and was independent with most ADLs and transfers. R42 was unable to ambulate and independently used a wheelchair for mobility. R42 had not exhibited any physical, verbal behaviors toward others and no wandering had occurred during the observation period. R42 had not exhibited any hallucinations, delusions, however, did have documented rejection of care. Diagnoses included paranoid schizophrenia, dementia, congestive heart failure, above the knee amputation, delusional disorders, generalized anxiety and post-traumatic stress disorder.			21810	Corrected		07/09/2026

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21810	Continued from page 5 R42's care plan revised 4/17/26, identified R42 was a pleasant man who was able to make his needs known. R42 was private and preferred his independent activities versus group programs. R42's interests included model cars, watching movies, music and going outside. Staff were directed to offer and escort R42 outdoors for programs or pleasure as weather allowed. R42's customary routine was identified that he enjoyed watching movies, working on his model cars, older music and smaller groups, but may not be able to stay if feeling anxious. R42 also enjoyed being outside. R42 had impaired mobility related to a right above the knee amputation, however, R42 was independent with transfer and activities of daily living (ADLs). On 6/1/26, at 12:32, R42 was observed seated in his wheelchair in his room. R42 was alert and able to move his wheelchair around his room and in the hallway independently. R42 stated he was not happy because he had always been able to go outside to the locked unit's fenced and secure courtyard whenever he liked to and now, he had been told he would not be able to go outside unless he was accompanied by a staff member. R42 stated it was because another resident had fallen out in the courtyard a few weeks ago and had been injured, but that resident should never have been allowed out there on her own in the first place. R42 stated he liked to go outside in the mornings when the weather was cooler and there was less wind but staff was not available to take him outside because they were busy with other resident cares. When the staff did take him outside, it was afternoon and hotter and he liked to sit out there alone, not with a group of people. R42 stated he had complained to the unit nurse, activities, social worker and administration but they just told him it was the rule for the unit. On 6/3/26, at 1:33 p.m. R42 was observed seated in the outside courtyard, in his wheelchair, visiting with R61. An unidentified staff member was seated nearby. The outside courtyard had a cement walkway and patio and a gazebo as well as grassy areas. The courtyard was fenced with a high fence and the gate was locked. R42 was listening to music on his phone and R61 was playing along on his guitar. The unidentified staff member stood up and notified the two residents she had other things to do, and the residents needed to return inside the facility. The two residents were observed complaining and stated they wanted to stay outside and why did they have to go in but they eventually went inside the facility with continued verbal complaints. R42 returned to his room.			21810			07/09/2026

Minnesota Department of Health

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21810	Continued from page 6 When interviewed on 6/2/26, at 10:38 a.m. registered nurse (RN)-A stated residents were never really allowed to go to the outside courtyard without supervision, but staff only recently started to reinforce the rule, when a resident recently fell in the outer courtyard. The outside courtyard was a closed fenced area with a locked gate. The door to the outside area was locked and could only be accessed by a staff members badge or family could take a resident outside. There had been some conversation regarding if more cognitive intact residents could be assessed to go out on their own, but she had been told that staff should be with the residents at all times. So far, no residents had been assessed to see if they could safely go out to the secured courtyard independently. Another problem was the door to come inside was locked and so the resident would not have access back into the building. During interview on 6/4/26, at 9:10 a.m. the social worker (SW)-A stated she was struggling with the issue as well. There was no call system since the facility had changed how the door operated. She had questioned if there was some type of call, they could give the resident to use outside or if the resident could just use their cell phone to call. The facility used to have a different door that they could lock but a resident outside could still get in. SW-A had brought up R42's complaint to the interdisciplinary team (IDT) and they were working on it, attempting to figure out a way more cognitively intact residents could go outside without supervision. The other problem was there was no shade. The facility had thought of putting an umbrella up but there was a concern it could blow over in the wind. On 6/4/26, at 1:44 p.m. a joint interview was conducted with the administrator and the director of nursing (DON). The DON stated the facility recently updated their locks to make the building more secure. The facility had also identified a concern with the current staff practices of allowing residents to out into the secured courtyard unsupervised. The ground was uneven and an accident risk, so the facility implemented that staff needed to be out with the residents in that area to ensure safety. It had always been that way, and staff had just gotten lax on the rule. They had not had a chance to evaluate each resident to see if they could be deemed safe to go out to the courtyard. One resident had recently fallen into the courtyard and because of that fall, it was discovered that staff were allowing resident's go to outside alone. If R42 were to wheel out there and go off the sidewalk, there was a risk he could tip his chair. The facility did not have therapy or		21810			07/09/2026	

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NAME OF PROVIDER OR SUPPLIER Villa St Vincent				STREET ADDRESS, CITY, STATE, ZIP CODE 516 WALSH STREET , CROOKSTON, Minnesota, 56716			
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21810	Continued from page 7 nursing to assess how safe residents were when they were outside. The facility policy Resident Rights and Notification of Resident Rights, last reviewed 8/28/25, identified the facility acted to protect and ensure the rights of residents. Social services or designee would inform the residents of the Resident Rights at the time of admission and with changes to regulatory statute. Any time state or federal laws relating to resident rights or facility rules changed during the residents' stay, the residents would be promptly informed of the changes. The policy listed 45 resident rights which included exercise of rights, planning and implementing care, accommodation of needs, and grievances. The facility policy Chemical and Physical Restraints last reviewed 8/31/23, identified medical symptoms that warrant the use of restraints would be documented in the resident's medical record. Before a restraint was used the IDT would determine the presence of a medical symptom that required a restraint and how the restraint would treat the medical symptom, protect the resident's safety and assist the resident in attaining or maintaining their highest practicable level of physical and psychological wee-being. Alternative to the restraint and the risk benefits would be discussed with the residents. For the residents to be fully informed, the IDT would explain the context of the resident's condition and circumstances, and the potential risks and benefits of options under consideration. Alternatives would be considered and discussed with the resident or resident representative. SUGGESTED METHOD OF CORRECTION: The DON or designee could review policies and procedures, and update as needed; and ensure residents with expressed needs were assessed for ability and safety to access secured outside areas when they requested access. The DON could ensure assessments and care plans are up to date. Educate staff on the expectation and then audit for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21810			07/09/2026
21830	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 10 Subd. 10. Participation in planning treatment; notification of family members.			21830	Corrected		07/09/2026

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21830	Continued from page 8 (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.			21830			07/09/2026

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21830	Continued from page 9 (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to support a resident's expressed choice regarding smoking for 1 of 1 resident (R17) reviewed for resident choices. The facility failed to assess R17's request to smoke, evaluate options to accommodate the preference, and involve the interdisciplinary team after R17 repeatedly expressed a desire to resume smoking. Findings include: R17's quarterly Minimum Data Set dated 5/8/26, identified R17 had moderate cognition and was able to make her needs known. R17's diagnoses included dementia, anxiety, depression and diabetes. R17's smoking risk assessment dated 1/22/26, identified R17 had a history of smoking but did not plan on smoking during the stay at the facility. R17's care plan printed on 4/25/26, failed to address R17's smoking preference. R17's progress notes identified the following: On 5/5/26 at 8:56 a.m., R17 reported to licensed social worker (LSW)-A she wanted to go outside and			21830			07/09/2026

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21830	Continued from page 10 have a cigarette. On 5/18/26 at 9:07 a.m., R17 reported to LSW-A she missed smoking and wished she could still smoke. The facility failed to provide evidence of assessing R17 for ability to smoke safely off campus, since R17 expressed an interest in smoking. R17's care conference note dated 5/7/26 failed to identify discussions regarding R17's desire to smoke. On 6/2/26 at 10:30 a.m. R17 attended a resident council meeting held by the state agency (SA). R17 stated she wanted to smoke although she was told by staff that she couldn't. During interview on 6/2/26 at 11:12 a.m., R17 stated she had smoked for over 50 years prior to admission, was forced to quit smoking to be admitted to the nursing home and was not given the option to go off-site to smoke. During interview on 6/4/26 at 10:14 a.m., LSW-A stated all new residents were informed they could not smoke because the facility was a smoke-free campus and only two residents were "grandfathered in" and allowed to smoke. LSW-A stated R17 requested the desire to smoke on two occasions; however, LSW-A stated she had not documented follow up discussions with the interdisciplinary (IDT) team and the IDT team did not evaluate options to accommodate R17's preference. On 6/4/26 12:57 p.m., registered nurse (RN)-A stated residents with a history of smoking were assessed on admission by nursing and social services. The nursing assessment included questions regarding the resident's smoking history, whether they planned to smoke while a resident at the facility, and if they were provided information regarding being a non-smoking facility. RN-A stated she was aware that R17 wanted to smoke although had not completed a smoking assessment since admission. The facility maintained a blanket practice prohibiting smoking by new residents and failed to conduct the individualized assessment and consideration of options required by its own policy after R17 repeatedly expressed a desire to smoke. The undated facility Non-Smoking – Tobacco Free/Smoke Free Campus policy identified residents			21830			07/09/2026

Minnesota Department of Health

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21830	Continued from page 11 that wished to smoke were to sign in/out of the facility and leave the property to smoke. Upon admission, residents would be evaluated/assessed for safe smoking practices and ability to smoke independently if they chose to do so when they were off campus. Based on the assessment, the residents may be provided with equipment to aid in safety (such as a smoking apron) when they chose to smoke while off campus. The assessment further identified the facility would consult with the resident and/or the resident representative for alternate assistance to use off campus smoking options. SUGGESTED METHOD OF CORRECTION: The DON or designee could review policies and procedures, and update as needed; and ensure residents were assessed for ability and safety to accommodate resident expressed preferences when deemed safe and if possible. The DON could ensure assessments and care plans are up to date. Educate staff on the expectation and then audit for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			21830			07/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245484		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 1975 EAST ... B. WING		(X3) DATE SURVEY COMPLETED 06/03/2026	
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K0000 Bldg. 02	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/03/2026. At the time of this survey, Villa St. Vincent was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			06/25/2026

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

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

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K0000 Bldg. 02	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. 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 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.			K0000			06/25/2026

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K0000 Bldg. 02	Continued from page 2 The facility has a capacity of 104 beds and had a census of 98 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:			K0000			06/25/2026
K0324 SS = F Bldg. 02	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: 1) 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. 2) Based on observation and interview, the facility failed to install the kitchen hood extinguishing system in accordance with NFPA 101 (2012 edition), The Life Safety Code, section 19.3.2.5, 19.3.2.5.1, 19.3.2.5.2*, 9.2.5, NFPA 96 (2011 edition) Ventilation Control and Fire Protection of Commercial Cooking Operations, section 12.1.2.3 and 12.1.2.3.1. These deficient			K0324	K0324 – Cooking Facilities Corrective Action: Hood inspection completed; appliances secured with restraints and alignment markings. Other Areas Reviewed: All cooking equipment evaluated to see if restraints needed and alignment markings in place. Systemic Changes: Service company replaced with a new contractor and task put into TELS to be reviewed every 6 months. Monitoring: Semi-annual review of inspection documentation reviewed by Plant Operations Manager or designee. Completion Date: 07/09/2026		07/09/2026

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K0324 SS = F Bldg. 02	Continued from page 3 findings could an isolated impact on the residents within the facility. Findings Include: 1. On 06/03/2026, at 11:27am, it was revealed by a review of available documentation that inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed test/inspection documentation for both of the semi-annual kitchen hood suppression system inspections for the last 12 months. 2. On 06/03/2026, at 12:45pm, it was revealed that the wheeled, gas-fired stove and griddle located on the cooking line in the kitchen was not provided with an approved method of attachment and/or an alignment mark to ensure the appliances was returned to an approved design location after it had been moved for maintenance and cleaning. Both the attachment device and alignment mark are required for each gas operated and deep fat fryer cooking device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0324			07/09/2026
K0353 SS = F Bldg. 02	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			K0353	K0353 – Sprinkler System Maintenance Corrective Action: Inspections completed; storage corrected for 18" clearance. Other Areas Reviewed: All storage areas inspected for proper clearance of 18" below the sprinkler heads. Systemic Changes: Task added to TELS to be checked every 3 months by Plant Operations Manager or designee Monitoring: Monthly x3 then Quarterly per TELS task. Completion Date: 07/09/2026		07/09/2026

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K0353 SS = F Bldg. 02	Continued from page 4 This STANDARD is NOT MET as evidenced by: 1) 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. 2) 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, Section 8.6.5.3.2. These deficient findings could an isolated impact on the residents within the facility. Findings include: 1. On 06/03/2026, at 11:10am, it was revealed by a review of available documentation the facility failed to perform all of the quarterly sprinkler system testing. 2. On 06/03/2026, at 12:31pm, 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 the main house keeping storage room. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0353			07/09/2026
K0712 SS = F Bldg. 02	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.			K0712	K0712 – Fire Drills Corrective Action: Fire drills completed per NFPA regulation since April of 2026 Other Areas Reviewed: Documentation reviewed for all shifts. Systemic Changes: Drill schedule implemented in TELS per shift. Monitoring: Quarterly review by Executive Director or Designee x 2. Completion Date: 07/09/2026		07/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245484		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 1975 EAST ... B. WING		(X3) DATE SURVEY COMPLETED 06/03/2026	
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K0712 SS = F Bldg. 02	Continued from page 5 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/03/2026, at 10:54am, it was revealed by a review of available documentation that fire drills were not completed. These fire drills were in first, third and fourth quarter. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0712			07/09/2026
K0741 SS = F Bldg. 02	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.			K0741	K0741 – Smoking Regulations Corrective Action: Area cleaned; staff re-educated. Other Areas Reviewed: All smoking areas inspected for cleanliness and proper disposal of cigarette butts. Systemic Changes: Policy reinforced; supervisory accountability established. Monitoring: Daily compliance rounds. Completion Date: 07/09/2026		07/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245484		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 1975 EAST ... B. WING		(X3) DATE SURVEY COMPLETED 06/03/2026	
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K0741 SS = F Bldg. 02	Continued from page 6 18.7.4, 19.7.4 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to implement a staff smoking policy per NFPA 101 (2012 edition), Life Safety Code section 19.7.4. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/03/2026, at 12:13 PM, it was revealed by observation that smoking was occurring by the smoking shack outside of the facility, and discarded cigarette butts and a visible pack of cigarettes were found on the ground. An interview with the Maintenance Director verified this deficient finding at the time of discovery			K0741			07/09/2026
K0511 SS = E Bldg. 02	Utilities - Gas and Electric CFR(s): NFPA 101 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 STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to provide a clear path to 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 9.1.2 and NFPA 70 (2012 edition), National electrical Code, sections 110.26 (A) (2). These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 06/03/2026 at the following times, it was revealed by observation that the electrical panel located in the following locations were blocked by linen handcart. 1) at 12:11pm, in electrical room 1			K0511	K0511 – Utilities Corrective Action: Obstructions removed from electrical panels. Other Areas Reviewed: All rooms with electrical panels inspected for clearance. Systemic Changes: Task added in TELS for every 6 month check; staff educated. Monitoring: All electrical panels inspected for 36 inch clearance monthly x3 by Plant Operations Manager or designee Completion Date: 07/09/2026		07/09/2026

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K0511 SS = E Bldg. 02	Continued from page 7 2) at 12:34pm, in electrical room 2 An interview with the Director of Maintenance verified these deficient findings at the time of discovery.			K0511			07/09/2026
K0223 SS = D Bldg. 02	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to ensure that the doors to high hazard room would close and latch with power of self-closing device per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3 and 19.3.2.1.5. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 06/03/2026, at 12:28pm, it was revealed by observation that the door at the soiled utility room by room 209 did not close and latch when tested. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0223	K0223 – Doors with Self-Closing Devices Corrective Action: Door repaired to ensure self-closing and latching. Other Areas Reviewed: All hazardous area doors inspected facility-wide. Systemic Changes: Preventive maintenance updated and included in TELS to be checked twice per year; staff re-educated. Monitoring: Monthly audits x3 by Plant Operations Manager or designee. Completion Date:07/09/2026		07/09/2026
K0372 SS = D Bldg. 02	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101			K0372	K0372 – Smoke Barrier Corrective Action: Penetration sealed with fire-rated		07/09/2026

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K0372 SS = D Bldg. 02	Continued from page 8 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD 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 a isolated impact on the residents within the facility. Findings include: On 06/03/2026, at 11:48am, it was revealed by observation that there was a penetration running from one smoke compartment to another above smoke compartment doors located by room 141. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0372	Continued from page 8 material. Other Areas Reviewed: Above-ceiling inspections completed facility-wide. Systemic Changes: Semi Annual inspection added to TELS. This task will be completed by Plant Operations Manager or designee Monitoring: Monthly x3 then semiannual per TELS task Completion Date: 07/09/2026		07/09/2026
K0781 SS = D Bldg. 02	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to ensure that portable space heater was in compliance with code requirements per NFPA 101			K0781	K0781 – Portable Space Heaters Corrective Action: Non-compliant heater removed. Other Areas Reviewed: Facility-wide sweep completed. Systemic Changes: Task added to TELS to checked every 6 months, Policy to be reinforced; staff educated. Monitoring: Monthly x3 by Plant Operations Manager or designee of random areas including offices and resident rooms. Completion Date: 07/09/2026		07/09/2026

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K0781 SS = D Bldg. 02	Continued from page 9 (2012 edition), Life Safety Code, section 19.7.8. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 06/03.2026, at 11:59am, it was revealed by observation of portable space heaters in the charge nurses office on MCU wing was not in compliance with life safety code. The space heater is not rated for less than 212 degrees and fails to meet additional requirements. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0781			07/09/2026