Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 31, 2023

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

Re: Reinspection Results
Event ID: 9DI312 and 53DD12

Dear Administrator:

On December 30, 2022 and January 24, 2023, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the surveys completed on November 10, 2022 and December 28, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 31, 2023

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

RE: CCN: 245449
Cycle Start Date: November 10, 2022

Dear Administrator:

On November 29, 2022, we notified you a remedy was imposed. On December 30, 2022 and January 24, 2023 the Minnesota Departments of Health and Public Safety completed revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 23, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 26, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 29, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 26, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 23, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

Electronically delivered
November 29, 2022

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

RE: CCN: 245449
Cycle Start Date: November 10, 2022

Dear Administrator:

On November 10, 2022, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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 Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 10, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 10, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 10, 2023.

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 $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by February 10, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, St Crispin Living Community will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 10, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program

Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 10, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@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) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded

by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245257	A. BUILDING ______ B. WING ______	11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OTTOS CARE CENTER	920 SOUTHEAST 4TH STREET LITTLE FALLS, MN 56345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 11/7/22-11/10/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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.	E 000		
F 000	INITIAL COMMENTS On 11/7/22-11/10/22, a standard recertification survey 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 facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 604 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.	F 604		12/9/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 12/01/2022

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

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F 604	Continued From page 1 The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical 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 record review the facility failed to assess for restraints for 1 of 1 residents (R44) reviewed for use of a seatbelt. Findings include: R44's quarterly Minimum Data Set (MDS) dated	F 604	F604 Right to be Free from Physical Restraints F604 CFR(s): 483.10(e)(1), 483.12(a)(2) St. Otto's Care Center intends to develop and implement policies and procedures to protect the Right to be Free from Physical Restraints. This will be completed by:	

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	245257	A. BUILDING ______ B. WING ______	11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OTTOS CARE CENTER	920 SOUTHEAST 4TH STREET LITTLE FALLS, MN 56345

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F 604 Continued From page 2

10/21/22, identified R44 was not able to understand others or communicate his needs. R44's skills for daily decision making were severely impaired. R44's MDS indicated no restraints.

R44's face sheet dated 11/9/22, indicated R44's diagnoses include epilepsy (seizure disorder), cerebral atrophy (loss of brain cells) and profound intellectual disabilities.

R44's medical record lacked a physical assessment, progress notes indicating use and physician orders for use of a restraint.

During an observation on 11/7/22, at 3:45 p.m. R44 was seated in his wheelchair in the facility day room. A seat belt, secured to the back of the wheelchair, was latched closed at R44's waist. R44 was not restless and his eyes were closed. No staff were in the day room.

On 11/9/22, at 7:43 a.m. nursing assistant (NA)-D stated she frequently worked with R44 and was familiar with his care needs. NA-D stated she sometimes secured the seatbelt for R44, depending on his mood. NA-D was not aware if there was an order for R44's seatbelt and confirmed it was not on the care plan. NA-D acknowledged use of the seatbelt was considered a restraint, but felt he was "grandfathered in" because he used it at his previous facility. NA-D stated she used the seatbelt when R44 was upset, after getting direction from the nurse.

On 11/9/22, at 7:47 a.m. licensed practical nurse (LPN)-C indicated use of a restraint required an assessment and orders. LPN-C confirmed R44 did not have physician orders or an assessment

F 604

Friday, December 9, 2022

The facility failed to assess for restraints for 1 of 1 resident (R44) reviewed for using a seatbelt.

A.Correction to residents: R44's resident's seatbelt and foot straps were removed from their wheelchair on 11/11/22.

B.Process put in place to prevent from reoccurring
a.All residents were audited for the use of physical restraints.
b.The Restraint Policy was reviewed on 11/12/22, and education was provided to all nursing staff at the nursing meeting on 11/17/22. Education will continue until all nursing staff has been educated on the restraint policy and procedure.

C.Auditing Plan
a.Wheelchairs and devices will be audited by DON or designee on new admissions to ensure no restraints are in place. If necessary, Restraint Policy will be followed as appropriate.
b.The DON or designee will complete weekly audits based on the MDS schedule for the completion of an up-to-date safety risk and elopement assessment.
c.Audit results will be reported at QAPI monthly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ST OTTOS CARE CENTER	**920 SOUTHEAST 4TH STREET LITTLE FALLS, MN 56345**

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F 604	Continued From page 3 to use the seatbelt. LPN-C stated she had not given instruction for use of the seatbelt and had not seen it in use. On 11/9/22, at 9:55 a.m. registered nurse (RN)-A confirmed use of restraints required an assessment, care planning, and orders. RN-A stated she was not aware of residents in the facility currently assessed for or approved for use of restraints. On 11/9/22, at 10:07 a.m. director of nursing (DON) stated there were no restraints in use in the facility. DON was aware R44 had a seatbelt on his wheelchair, it was on the wheelchair when R44 admitted. DON indicated she did not feel R44's seatbelt was warranted at this time as his seizures are well controlled. Facility policy Restraint Use reviewed date 5/2019, indicated the need for restraint use is assessed on admission, at regularly scheduled interdisciplinary care plan conference reviews and as needed. A physician order is required prior to applying any type of restraint. Documentation with restraint use include pre-restraining assessment, fall risk assessment, MD order, family consent and quarterly review/reduction and daily documentation of every two hours release.	F 604		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		12/9/22

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F 684	Continued From page 4 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to properly assess for self-administration of medications. This had the potential to affect 1 of 1 residents (R47) reviewed for self-administration of medications. Findings include: R47's quarterly Minimum Data Set (MDS) dated 10/14/22, indicated R47 was sometimes able to understand others and was sometimes able to make himself understood. R47's cognition was severely impaired. R47's cognition was unchanged from his baseline. R47's face sheet dated 11/10/22, indicated R47's diagnoses included chronic obstructive pulmonary disease (COPD- disease causing breathlessness and cough), traumatic brain injury and dementia. R47's signed physician's orders dated 9/1/22-9/30/22, indicated R47 had orders for ipratropium-albuterol 0.5mg-3mg (medication to treat COPD) inhaled by nebulizer every two hours as needed. R47's physician's orders did not include orders to self-administer medications, including nebulizers. R47's care plan lacked instructions for self-administration of medications. R47's medical record failed to include an assessment for self-administration of	F 684	F684 CFR(s): 483.25 Quality of Care St. Otto's Care Center intends to develop and implement policies and procedures for the self-administration of medications. This will be completed by: Friday, December 9, 2022 The facility failed to assess for self-administration of medications properly for 1 of 1 resident (R47). A.Correction to residents a. R47's self-administration assessment, MD order, and care plan were updated on 11/11/22. B.Process put in place to prevent from reoccurring a. All residents using nebulizers were audited for compliance with a self-administration assessment, MD orders were obtained, and care plans were revised. b. Policy and Procedure on Self-Administration of Medications were reviewed on 11/16/22. Education on the Policy and Procedure of Self-Administration of Medications was provided to nursing staff on 11/17/22. Education will continue until all nursing staff has been educated on the Self-	

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F 684	Continued From page 5 medications. On 11/8/22, at 12:50 p.m. licensed practical nurse (LPN)-B was observed setting up an unknown medication in R47's nebulizer, placed the face mask on R47, turned on the machine and left the room. On 11/8/22, 12:56 p.m. LPN-B returned to R47's room. LPN-B made no adjustments to the nebulizer machine or mask and left the room and area of R47's room. On 11/8/22, at 1:04 p.m. LPN-B returned to R47's room. LPN-B turned off the nebulizer machine and removed the face mask. On 11/9/22, at 7:16 a.m. LPN-B set up an unknown medication in R47's nebulizer, placed the face mask on R47's face, turned the machine on and left the room. On 11/9/22, at 7:26 a.m. LPN-B returned to R47's room, turned off the nebulizer machine and removed the face mask. On 11/9/22, at 12:14 p.m. LPN-B confirmed the medication administered via nebulizer was ipratropium-albuterol. LPN-B stated for a resident to self-administer medications, including nebulizers, an assessment was completed. LPN-B stated, for R47, she was able to set up the medication, place the mask, turn on the machine and walk away if she continued to check on him. If LPN-B noted R47 having difficulty with the nebulizer, LPN-B would place her medication cart by R47's room while the nebulizer was running to keep a closer eye on him while continuing to pass medications to other residents. LPN-B confirmed	F 684	Administration of Medications policy and procedure. C.Auditing Plan a. All resident orders will be audited by the DON or designee weekly x 60 days for new nebulizer order for the completion of an up-to-date self-administration assessment. b. The DON or designee will complete weekly audits based on the MDS schedule for the completion of an up-to-date self-administration assessment. c. Audit results will be brought to QAPI monthly.	

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ST OTTOS CARE CENTER	920 SOUTHEAST 4TH STREET LITTLE FALLS, MN 56345

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F 684	Continued From page 6 R47 was not previously assessed for self-administration of medications and did not have order for self-administration of medications, including nebulizers. On 11/10/22, at 9:33 a.m. director of nursing (DON) confirmed self-administration of a nebulized medication occurred when the medication was set up, the mask placed, the machine turned on and staff left the immediate area of the resident. She expected staff to stay within eyesight of any resident receiving a nebulizer treatment unless they have been assessed and determined safe to self-administer medications. DON stated she expected a signed physician's order for self-administration, specific to the medication, as well as instructions in resident's care plan would be found in the resident's record. DON confirmed R47's medical record did not include an assessment for self-administration of medications and R47's physician's orders did not include orders for self-administration of medications. Facility policy, Self-Administration of Medications by Residents with revision date 7/28/14, directed the interdisciplinary team determines the resident's ability to self-administer medications by means of a skill assessment conducted on a quarterly basis.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical	F 688		12/9/22

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	245257	A. BUILDING ______ B. WING ______	11/10/2022

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F 688	Continued From page 7 condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure passive range of motion (PROM) was performed for 1 of 4 residents (R30) reviewed for positioning and mobility. This failure had the potential to affect any resident who needed assistance implementing restorative care interventions. Findings include: R30's face sheet indicated the resident was admitted to the facility on 12/30/21 with a diagnosis of a stroke on the left side. Review of a document provided by the facility titled "Restorative Nursing Program Therapy Recommendation," dated 01/25/22, indicated R30 was to receive PROM to the left upper extremity in all three planes. On the resident's right side, R30 was to use three-pound bar bells, upper extremity curls, and diagonal supination/pronation five to seven times per week.	F 688	F688 Increase/Prevent Decrease in ROM/Mobility F688 CFR(s): 483.25(c)(1)-(3) St. Otto's Care Center intends to develop and implement policies and procedures to address and offer a range of motion exercises to residents listed in the restorative nursing program as described in the resident□s plan of care based on therapy recommendations. This will be completed by: Friday, December 9, 2022 The facility failed to ensure a passive range of motion (PROM) was performed for 1 of 4 residents (R30). A.Correction to residents a. R30's Program was reviewed and updated on 11/29/2022. B. Process put in place to prevent from reoccurring a. All resident restorative programs will be	

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F 688	Continued From page 8 R30's quarterly Minimum Data Set (MDS) indicated the resident had intact cognition. The assessment indicated that R30 required extensive assistance of one staff member for bed mobility and transfers and was impaired on one side of his body, both upper and lower extremities. R30's care plan indicated alteration in mobility due to a past stroke with left sided hemiplegia (paralysis). The care plan intervention was to provide left side PROM to upper extremities for all planes of motion. The resident's right side was to use a three-pound bar bell, curls, diagonal, supination, and pronation. The range of motion was to happen 12 to 15 times per month. This care plan intervention contradicted the directions for PROM from skilled therapy. During an interview on 11/09/22, at 10:10 a.m. Certified Nursing Assistant (CNA)-A stated she did not provide restorative services to R30. During an interview on 11/09/22, at 10:15 a.m. CNA-B stated he did not provide restorative services to R30 since the facility utilized a restorative CNA. During an interview on 11/09/22, at 10:17 a.m. CNA-C stated she was the restorative aide but got pulled to the floor frequently. During an interview on 10/09/22, at 11:24 a.m. the Director of Rehabilitation (DOR)-A stated R30 was referred to restorative nursing after he had completed skilled services. DOR-A stated the benefit of a resident placed on restorative nursing services was to maintain mobility and function.	F 688	reviewed and updated as appropriate. b. The restorative Nursing Policy was reviewed on 11/15/22 and reviewed during a nursing meeting on 11/17/22. Education will continue until all nursing staff has been educated on restorative nursing and range of motion exercises. C. Auditing Plan a. Residents will be audited weekly X 60 days on Restorative Programs for compliance. b. The results of audits will be brought to QAPI monthly.	

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F 688	Continued From page 9 During an interview on 11/09/22, at 12:22 p.m. Licensed Practical Nurse (LPN)-A confirmed she supervised the restorative nursing program. LPN-A stated there had been no decline identified with R30. During an interview on 11/09/22, at 1:14 p.m. the Director of Nursing (DON)-B stated goals were set on a care plan in an attempt to achieve them for a resident and the facility does their best to accomplish the goals. During an interview on 11/10/22, at 8:59 a.m. DON-B stated her expectation for the restorative program would be to meet the restorative goals as directed by a resident's care plan. During a subsequent interview on 11/10/22, at 9:13 a.m. DON-B provided several documents which identified R30's sessions for the restorative program. The documents were titled "Nursing Rehab (Rehabilitation) Time Log." DON B stated for the month of 08/22 the resident received six restorative sessions. DON-B stated for the month of 09/22 the resident received 15 restorative sessions and for the month of 10/22 the resident received two restorative sessions. DON-B stated it was her expectation if the restorative aide was pulled to the floor, other CNAs were to complete the restorative sessions with the resident. DON-B stated the electronic medical record (EMR) prompted staff to identify the PROM ordered for the resident. During an interview on 11/10/22, at 9:50 a.m. R30 stated he completed his own PROM on his left arm. R30 stated no staff had worked with him with weights or on the left side which was affected by his stroke.	F 688		

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F 688	Continued From page 10 Review of a document provided by the facility titled "Restorative Nursing Policy," dated 06/15/22, indicated "...To incorporate interventions that promote a resident's ability to adapt and adjust to living safely and as independently as possible. It includes rehabilitation, management of behavioral symptoms, cognitive performance, and physical function..."	F 688		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to complete a performance review every 12 months for 2 of 3 nurse aides (NA-D & NA-E) reviewed for performance reviews. Findings include: NA-D's Employee Evaluation revealed her last performance review was completed on 08/30/19. NA-E's Employee Evaluation revealed his last performance review was completed on 06/01/18. On 11/10/21, at 9:00 a.m. the Director of Nursing (DON) verified last performance review was completed 8/30/19 for NA-D and 6/01/18 for	F 730	F 730 Nurse Aide Peform Review-12 hr/yr In-Service F730 CFR(s): 483.35(d)(7); 483.35(d)(7) Regular in-service education. St. Otto's Care Center intends to develop and implement policies and procedures to address Nursing Aide's Performance Reviews annually. This will be completed by: Friday, December 9, 2022 The facility failed to complete a performance review every 12 months for 2 of 3 nurse aides (NA-D & NA-E) reviewed for performance reviews. A. Correction to nursing aides	12/9/22

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F 730	Continued From page 11 NA-E. DON stated she was aware the performance reviews were late prior to the start of survey. Review of the undated "Employee Performance Evaluations" policy revealed it is the facility's policy to complete performance evaluations annually.	F 730	a. NA-D had their review completed on 11/29 & NA-E had their review completed on 12/1. B. Process put in place to prevent from reoccurring a. Policy and Procedure on Employee Performance Evaluations were reviewed on with the Director of Nursing for compliance standards on 11/22/2022. b. All nurse aide employee records were audited for compliance. Nursing performance reviews will be conducted weekly until compliance is met and processes are established. C.Auditing Plan a.The Administrator or designee will audit compliance weekly X 90 days and report results to QAPI monthly.	

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/10/2022. At the time of this survey, ST CRISPIN LIVING COMMUNITY Building 01 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/07/2022

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. ST CRISPIN LIVING COMMUNITY consists of two connected buildings: (BLDG 01) is a 1 story building with basement, and (BLDG 02) is a 2 story with no basement; (BLDG 02) is a 2 story building with partial basement that is attached to (BLDG 01), but separated by 2 hour fire wall construction. The facility was constructed at 2 different times. The original building (BLDG 01) is a 1 story building with a partial basement that was	K 000		

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K 000	Continued From page 2 constructed in 1977 and was determined to be of Type V (111) construction. (BLDG 01) underwent extensive remodeling in 2018. The addition (BLDG 02) is a 2 story building with partial basement that was constructed in 2018 and was determined to be of Type II (111) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility was surveyed as two separate buildings. The facility has a capacity of 64 beds and had a census of 54 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain visibility of a mean of egress per NFPA 101 (2012 edition), Life Safety Code, section 19.2.1, 7.1.10.2, 7.1.10.2.1. This	K 211	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or	12/10/22

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K 211	Continued From page 3 deficient condition could have an patterned impact on the residents within the facility. Findings include: On 11/10/2022 between 09:00 AM to 12:30 PM, it was revealed by observation during the walk-thru of the facility that an exit door adjacent to the Admin Office was visually obstructed with curtains, such that the door may not be readily identifiable or recognized as a point of egress An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 211	agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. K211 – Means of Egress – General The curtains were removed from the exit door on 11-10-22. No curtains will be placed in this area in the future. Environmental Services staff will monitor compliance by performing visual inspections weekly. Visual inspections will be documented on an audit tool when completed. Audits will be reviewed at monthly Safety Committee meetings scheduled every second Wednesday of the month at 11:30 a.m. Monitoring of compliance will be reported at monthly Quality Council Meetings scheduled every third Tuesday of the month at 2:00 p.m. Results of compliance monitoring will be reported to Quality Council for at least three months. Based on results of audit compliance, it will be determined if reporting needs to continue at Quality Council. Results of continued compliance will continue to be reported monthly to Safety Committee. Staff inservice will be conducted on Friday, December 9th at 2:00 p.m. outlining statements of deficiency and plans of correction. Employees will also receive a sign off sheet indicating they have read and understand the statements of deficiency and plans of correction. Complete Date: 12-10-22.	

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K 345	Continued From page 4	K 345		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the fire alarm system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3, 9.6.1.5, 19.3.4 and NFPA 72 (2010 edition), National Fire Alarm and Signal Code, section 17.14.5 This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 11/10/2022 between 09:00 AM to 12:30 PM, it was revealed by observation during the walk-through of the facility that the manual pull-station adjacent to the Admin Office was access obstructed An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	K345 – Fire Alarm System – Testing and Maintenance The wheelchair that was obstructing the manual pull station adjacent to the Administrator's office was removed on 11-10-22. A sign is located under the pull station stating "Notice – Fire Alarm Pull Station area. Keep Area Clean at All Times". The Hospitality/Reception Desk, Administrator and Social Worker will visually monitor this are while they are working. Environmental Services staff will monitor compliance by performing visual inspections weekly. Visual inspections will be documented by Environmental Services staff on an audit tool when completed. Audits will be reviewed at monthly Safety Meetings scheduled every second Wednesday of the month at 11:30 a.m. Monitoring of compliance will be reported at monthly Quality Council Meetings scheduled every third Tuesday of the month at 2:00 p.m. Results of compliance monitoring will be reported for	12/10/22

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K 345	Continued From page 5	K 345	at least three months. Based on results of audit compliance, it will be determined if reporting needs to continue at Quality Council. Results of continued compliance will continue to be reported monthly to the Safety Committee. Staff inservice will be conducted on Friday, December 9th at 2:00 p.m. Employees will also receive a sign off sheet indicating that they have read and understand the statements of deficiency and plans of correction. Complete Date: 12-10-22.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, document review, and staff interview, the facility failed to test and	K 353	K353 – Sprinkler System – Maintenance and Testing	12/10/22

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

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K 353	Continued From page 6 maintain the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 19.3.5, 9.7, 9.7.5, NFPA 13 (2010 edition) Standard for the Installation of Sprinkler Systems, section 8.5.6, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 4.1.5.2, 5.2, 5.2.1.2, 5.2.2.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 11/10/2022 between 09:00 AM to 12:30 PM, it was revealed by observation during walk-through of the facility that floor level assessment of sprinkler heads revealed the following: a. In the Kitchen / Dishwashing area there was a hole in the ceiling that could permit the transmission of smoke, heat, fire into the area above the ceiling b. In the Med Storage Room there was a missing ceiling tile which would permit the transmission of smoke, heat, fire into the area above the ceiling c. In the Data Room there were cables that had been zip-tied to the sprinkler system piping d. In the Basement - Activities Room, there was high storage of items which could affect the proper operation of the sprinkler system and head 2. On 11/10/2022 between 09:00 AM to 12:30 PM, it was revealed during documentation review that there was no documentation presented to confirm that quarterly inspections of the sprinkler system are occurring. An interview with the Maintenance Director	K 353	Regarding findings, the following was completed: 1. The hole in the ceiling in the kitchen/dishwashing are was repaired. 2. The missing ceiling tile in the Med Storage area was replaced. 3. The zip ties that were attached to the sprinkler system piping were removed. 4. Activity storage located in the basement was moved to a lower position, to allow for proper operation of the sprinkler. 5. The Environmental Services staff has been assigned to complete and document the quarterly inspections of the sprinkler system. Environmental Services staff will visually monitor compliance weekly by completing inspections of the building. Visual inspections will be documented by Environmental Services staff on audit tool. Audits will be reviewed at monthly Safety Committee meetings scheduled every second Wednesday of the month at 11:30 a.m. Monitoring of compliance will be reported at monthly Quality Council meetings scheduled every third Tuesday of the month at 2:00 p.m. Based on results of audit compliance, it will be determined if reporting needs to continue at Quality Council meetings. Staff inservice will be held on December 9th at 2:00 p.m. outlining statements of deficiency and plans of correction. Employees will also receive a sign off sheet indicating that they have read and understand the statements of deficiency and plans of correction. Complete Date:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING **01 - MAIN BUILDING 01** B. WING ____	**11/10/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 7 verified these deficient findings at the time of discovery.	K 353	12-10-22.	
K 511 SS=E	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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper physical clearance to electrical panels in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 70 (2011 edition), National Electrical Code, section 110.26 This deficient finding could have a patterned impact on the residents within the facility. Findings include: 1. On 11/10/2022 between 09:00 AM to 12:30 PM, it was revealed by observation during the walkthrough of the facility that the Electrical Closet located in the Lobby Area was being used for combustible storage and had combustible storage leaning against and obstructing access to the electrical service panels.	K 511	K511 – Utilities – Gas and Electric Regarding the findings, the following was completed: 1. The electrical closet in the lobby area was cleaned. All combustible materials were removed. If it necessary to stored items in this closet, they will be stored in plastic bins that will not obstruct access to the electrical panels. 2. The items in the Mechanical Room were removed from in front of the electrical panel. Fire area tape was placed in front of the electrical panel so items will not be placed in this area that will obstruct the electrical panel. Environmental Services staff will monitor compliance by performing visual	12/10/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**11/10/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 511	Continued From page 8 2. On 11/10/2022 between 09:00 AM to 12:30 PM, it was revealed by observation during the walkthrough of the facility that the Mechanical Room there were items placed directly in front of and obstructing access to the electrical panels An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 511	inspections weekly. Visual inspections will be documented on an audit tool when completed. Audits will be reviewed at monthly Safety Meetings scheduled every second Wednesday of the month at 11:30 a.m. Monitoring of compliance will be reported at monthly Quality Council meeting scheduled every third Tuesday of the month at 2:00 p.m. Based on results of audit compliance, it will be determined if reporting needs to continue at Quality Council meetings. Results of continued compliance will be reported monthly to the Safety Committee. Staff inservice will be conducted on Friday, December 9th at 2:00 p.m. outlining statements of deficiency and plans of correction. Employees will receive a sign off sheet indicating that they have read and understand the statements of deficiency and plans of correction. Complete date: 12-10-22.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40	K 918		12/10/22 12/14/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING **01 - MAIN BUILDING 01** B. WING ____	**11/10/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 9 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain, inspect, and test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1, 6.4.4.2 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4, 8.4.9 through 8.4.9.7. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 11/10/2022 between 09:00 AM to 12:30 PM, it was revealed during documentation review that no documents were presented for review to	K 918	K918 Electrical Systems – Essential Electric System Maintenance and Testing Pioneer Critical Power was contacted to schedule an appointment for the once every 36 months – 4 hour continuous run of the emergency generator. An appointment is scheduled for December 14th, 2022. Facility will schedule an appointment for this requirement to be completed every three years. Environmental Services staff will be responsible for the scheduling of this test and making certain that this requirement is completed. Staff inservice will be conducted on Friday, December	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**11/10/2022**

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

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K 918	Continued From page 10 confirm that the once every 36 months - 4 hour continuous run of the emergency generator is being completed An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	9th at 2:00 p.m. outlining statements of deficiency and plans of correction. Employees will also receive a sign off sheet indicating that they have read and understand the statements of deficiency and plans of correction. Complete Date: 12-10-22.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order	K 923		12/10/22

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	245449	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	11/10/2022

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

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K 923	Continued From page 11 of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 5.1.3.3.2(2), 5.1.3.3.4, 5.1.3.3.4.1, 11.3, 11.3.2, 11.3.2.3, 11.3.4, 11.6.2, 11.6.2.3(3), 11.6.5, NFPA 55 (2010 edition), Compressed Gases and Cryogenic Fluids Code, sections 7.1.4.2.1, 7.1.8.4, 7.1.8.1, 7.1.8.2. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 11/10/2022 between 09:00 AM to 12:30 PM, it was revealed by observation during the walkthrough of the facility that the Med Gas Storage Room (O2) was found to be unsecured. An interview with the Maintenance Director verified this deficient finding at the time of discovery	K 923	K923 Gas Equipment – Cylinder and Container Storage The Med Gas Storage Room (O2) was immediately locked on 11-10-22. A key pad lock will be placed on this door. Staff inservice will be conducted on Friday, December 9th at 2:00 p.m. outlining statements of deficiency and plans of correction. Complete Date: 12-10-22.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING **02 - ST CRISPIN LIVING COMMUNITY** B. WING ______	**11/10/2022**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 11/11/2022. At the time of this survey, ST CRISPIN LIVING COMMUNITY Building 02 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/07/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING **02 - ST CRISPIN LIVING COMMUNITY** B. WING ______	**11/10/2022**

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. ST CRISPIN LIVING COMMUNITY consists of two connected buildings: (BLDG 01) is a 1 story building with basement, and (BLDG 02) is a 2 story with no basement; (BLDG 02) is a 2 story building with partial basement that is attached to (BLDG 01), but separated by 2 hour fire wall construction. The facility was constructed at 2 different times. The original building (BLDG 01) is a 1 story building with a partial basement that was	K 000		

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	245449	A. BUILDING **02 - ST CRISPIN LIVING COMMUNITY** B. WING ______	**11/10/2022**

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

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K 000	Continued From page 2 constructed in 1977 and was determined to be of Type V (111) construction. (BLDG 01) underwent extensive remodeling in 2018. The addition (BLDG 02) is a 2 story building with partial basement that was constructed in 2018 and was determined to be of Type II (111) construction. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility was surveyed as two separate buildings. The facility has a capacity of 64 beds and had a census of 54 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source	K 353		12/10/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING **02 - ST CRISPIN LIVING COMMUNITY** B. WING	11/10/2022

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K 353	Continued From page 3 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, document review, and staff interview, the facility failed to test and maintain the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 19.3.5, 9.7, 9.7.5, NFPA 13 (2010 edition) Standard for the Installation of Sprinkler Systems, section 8.5.6, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 4.1.5.2, 5.2, 5.2.1.2, 5.2.2.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 11/10/2022 between 09:00 AM to 12:30 PM, it was revealed by observation during walk-through of the facility that floor level assessment of sprinkler heads revealed the following: a. In the Clinical Managers Office, items were found to have been placed less-than 18 inched from the sprinkler head which could affect the proper operation of the sprinkler system and head b. In the Spruce Hill Laundry Room, there was a missing ceiling tile which would permit the transmission of smoke, heat, fire into the area above the ceiling 2. On 11/10/2022 between 09:00 AM to 12:30 PM, it was revealed during documentation review that there was no documentation presented to	K 353	K353 Sprinkler System – Maintenance and Testing Regarding findings, the following were completed: 1. Items in the Clinical Manager's office found to have been placed less than 18 inches from the sprinkler head were removed. 2. The missing ceiling tile in the Spruce Hill Laundry Room was replaced. 3. Maintenance staff were re-educated on completing quarterly sprinkler logs. This information was formerly put on the TELS System internally. It will now be recorded in the Quarterly Sprinkler logs by Environmental Services staff. Records will be kept in the Generator Log Book. Generator Log Book information will be reviewed at monthly Safety meetings scheduled every second Wednesday of the month at 11:30 a.m. Monitoring of compliance will be reported at the monthly Quality Council meeting scheduled for every third Tuesday of the month at 2:00 p.m. for at least three months. Based on results of audit compliance, it will be determined if reporting needs to continue at Quality Council meetings. Staff inservice will be held on Friday, December 9th at 2:00 p.m. outlining statements of deficiency and plans of correction.	

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K 353	Continued From page 4 confirm that quarterly inspections of the sprinkler system are occurring. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	Employees will also receive a sign off sheet indicating that they have read and understand the statements of deficiency and plans of correction. Complete Date: 12-10-22.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing	K 918		12/10/22 12/14/22

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 5 the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain, inspect, and test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1, 6.4.4.2 and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4, 8.4.9 through 8.4.9.7. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 11/10/2022 between 09:00 AM to 12:30 PM, it was revealed during documentation review that no documents were presented for review to confirm that the once every 36 months - 4 hour continuous run of the emergency generator is being completed An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	K918 Electrical Systems – Essential Electric System Maintenance and Testing Pioneer Critical Power was contacted to schedule an appointment for the once every 36 months – 4 hour continuous run of the emergency generator. An appointment is scheduled for December 14th, 2022. Facility will schedule an appointment for this requirement to be completed every three years. Environmental Services staff will be responsible for the scheduling of this test and making certain that this requirement is completed. Staff inservice will be conducted on Friday, December 9th at 2:00 p.m. outlining statements of deficiency and plans of correction. Employees will also receive a sign off sheet indicating that they have read and understand the statements of deficiency and plans of correction. Complete Date: 12-10-22.	

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

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"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245449	MULTIPLE CONSTRUCTION A. BUILDING: **02 - ST CRISPIN LIVING COMMUNITY** B. WING ___	DATE SURVEY COMPLETE: **11/10/2022**
NAME OF PROVIDER OR SUPPLIER **ST CRISPIN LIVING COMMUNITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **213 PIONEER ROAD RED WING, MN**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 511	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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper physical clearance to electrical panels in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.5.1.1 and 9.1.2, NFPA 70 (2011 edition), National Electrical Code, section 110.26 This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 11/10/2022 between 09:00 AM to 12:30 PM, it was revealed by observation in the Sprucehill Corridor that electrical panels (EP1, 3, 4) were unsecured in a resident accessible corridor. The Maintenance Director immediately contacted Staff and the electrical panels were secured during survey. An interview with the Maintenance Director verified this deficient finding at the time of discovery.

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

The above isolated deficiencies pose no actual harm to the residents

Electronically delivered
November 29, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: 9DI311

Dear Administrator:

The above facility was surveyed on November 7, 2022 through November 10, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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:

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: ______ B. WING ______	11/10/2022

PENDING ACKNOWLEDGEMENT

NAME OF PROVIDER OR SUPPLIER: **ST CRISPIN LIVING COMMUNITY**

STREET ADDRESS, CITY, STATE, ZIP CODE: **213 PIONEER ROAD, RED WING, MN 55066**

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2 000	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: Revised due to IDR process. On 11/7/22 - 11/10/22, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 12/07/22

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PENDING ACKNOWLEDGEMENT

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ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

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2 000	Continued From page 1 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 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,	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 2 "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.	2 000		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide toenail care for 1 of 1 residents (R42) reviewed for dependant cares. Findings include: R42's Minimum Data Set (MDS) reviewed on 11/09/22, 11:21a.m. dated 9/22/22, indicated severely impaired cognition, memory problems and inattentive. R42 required assist of 2 for bed mobility, transfers, dressing, eating, toilet needs and personal hygiene. Diagnoses of Alzheimer's disease, Essential Tremor, sensorineural hearing loss (bilateral), other malaise, and muscle weakness. R42's care plan (CP) last revised 9/23/22, indicated self-deficit with activities of daily living	2 860	Complete	12/10/22

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2 860	Continued From page 3 (ADL); bathing, grooming, and oral cares. R42 required staff to anticipate his needs. R42's Body Audit Form notes indicated toenail care was completed on 10/24/22. During an observation on 11/09/2022, at 8:22 a.m. nursing assistant (NA)-A revealed thick toenails on right and left feet. Right and left foot toenails have several toes that have nails extending beyond the toes. NA-A stated R42 saw the podiatrist. NA-A stated toenails were "thick and long". During an interview on11/09/2022, at 9:26 a.m. RN-B reported RNs conduct weekly skin assessments. This process included all skin, fingernails, and toenails. Documentation of skin observation goes into the clinical manager's slot. It was then uploaded to the electronic medical record. Nurses were prompted in electronic medical record when this task was due. Nurses review the Body Audit Form weekly that nursing assistants complete with bathing. Concerns should be reported to the nurse. An event was started in Matrix if it's a new onset. They monitor and document. During an interview and observation 11/09/22, at 09:30 a.m. registered nurse (RN)-A was unable to locate resident on podiatry list. RN-A stated aides provided nail care with baths. "Bath Book" indicated R42's toenails were trimed 10/24/22. However, RN-A stated R42's toenails were longer than she expected. RN-A measured toenails from end of toes: 0.5 cm 3rd toe, 0.3cm 4th on toe left foot 0.7cm 3rd, 0.7cm 4th toe on right foot. During an interview on 11/09/22, at 09:45 a.m. interview with RN-B indicated process was for	2 860		

PENDING ACKNOWLEDGEMENT

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2 860	Continued From page 4 nursing assistants to report any skin or nail concerns to floor nurse. Floor nurse was to review skin assessment each week. Floor nurse to review bath book notes which included skin and nails. SUGGESTED METHOD OF CORRECTION: The facility could educate staff regarding nail care of dependent resident polices and procedures. The facility could educate staff regarding process of skin assessments, nail care and documentation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 860		