Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 7, 2025

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

RE: CCN: 245449
Cycle Start Date: February 27, 2025

Dear Administrator:

On April 9, 2025, we notified you a remedy was imposed.

On April 1-2, 2025, the Minnesota Departments of Health and Public Safety completed revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 30, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 27, 2025, did not go into effect. (42 CFR 488.417 (b))

In our letter of April 9, 2025, 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 May 27, 2025, due to denial of payment for new admissions. Since your facility attained substantial compliance on April 30, 2025, 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 Therefore, the NATCEP prohibition is rescinded.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 Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 7, 2025

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

Re: Reinspection Results
Event ID: A92N12

Dear Administrator:

On April 1, 2025, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 27, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 14, 2025

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

RE: CCN: 245449
Cycle Start Date: February 27, 2025

Dear Administrator:

On February 27, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by May 27, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 27, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 14, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: A92N11

Dear Administrator:

The above facility was surveyed on February 24, 2025 through February 27, 2025 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:

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

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

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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 02/27/2025

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
E 000	Initial Comments On 2/24/25 to 2/27/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities 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 2/24/25 to 2/27/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54498382C (MN00110900, MN00110779, MN00110901), H54493940C (MN00109467), H54498521C (MN00110885). NO citations were issued. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to	F 000		

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

Electronically Signed | 03/20/2025

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 000	Continued From page 1 validate substantial compliance with the regulations has been attained.	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880		3/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 2 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to properly bag and contain contaminated linen placed under a basket of clean resident laundry and maintain a clean laundry room used for resident personals. This had the potential to affect all 15 residents on the 300 unit.	F 880	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies.	

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F 880	Continued From page 3 Findings include: During a tour of the 300-unit laundry room on 2/26/25 at 7:32 a.m., registered nurse (RN)-A stated dirty linens are bagged and put in the soiled utility room to be picked up by housekeeping staff on each unit and taken to the main utility room to be picked up by a contracted linen company. The process for resident clothing is completed by nursing assistant (NA)'s on resident's bath day. NA's bring resident's personal laundry to the unit laundry room, washes and dries the items and places them back in a basket on wheels. The basket on wheels is taken to the resident room to be folded or hung. The NA's used a dry erase board to communicate to other staff what residents' items are in each machine. The 300-unit laundry room had an unbagged yellow-stained contaminated bed sheet on the floor; with residents' clean personal laundry sitting in the basket on wheels above the contaminated linen. The floor of laundry room was dirty with used lint scraps under the sink and under basket on wheels. There was a used paper towel under the sink. Lint pieces were stuck to the white board and along floorboards. The detergent compartment on the washer was dirty with lint scraps and old soap. RN stated they used to use the pods for detergent but had recently switched to Ecolab products and the detergent was now completed with this system. The 300-laundry room smelled of wetness and mildew . During an interview on 2/26/25 at 7:22 a.m., maintenance (M)-A stated resident personal laundry is completed in the laundry rooms on each unit. M-A stated he does not collect dirty linens from unit laundry rooms.	F 880	The plan of correction is prepared and/or executed in accordance with federal and state law requirements. The unbagged soiled bedding was immediately removed, properly bagged, and placed appropriately within the soiled linen bin within the soiled utility room according to facility policy. The laundry room was cleaned and disinfected to eliminate any potential contamination. The other three laundry rooms were checked for any unbagged soiled linens with none discovered. The facility's Laundry and Linen Policy was reviewed to identify gaps that may have contributed to the deficiency. Re-education of Staff: The Linen and Laundry Policy (POL_IP081) was reviewed and reinforced with all nursing associates. Beginning on 2/26/25, all nursing associates received re-education on proper linen handling, including segregation of clean and soiled laundry, per facility policy. Training emphasized the importance of bagging soiled linen immediately at the point of use to prevent cross-contamination. Staff completed a competency quiz to demonstrate understanding. Monitoring Procedure to Ensure Compliance: Weekly audits of facility laundry rooms will	

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F 880	Continued From page 4 During an observation and interview on 2/26/25 at 8:30 a.m., NA-A stated it was the responsibility of the NA's to keep the unit laundry room tidy and clean. The wetness and mildew smell remained, the garbage remained, and the soiled bedsheet remained on the floor. During an interview on 2/26/25 at 9:05 a.m., housekeeper (H)-A stated the NA's do the laundry and keep the laundry room clean. She does the housekeeping for the resident rooms and common areas. During an observation and interview on 2/26/25 at 10:24 a.m., director of nursing (DON) and regional registered nurse (RRN) viewed the 300-unit laundry room. RRN confirmed there is a yellow-stained unbagged dirty bed sheet sitting beneath resident clean laundry in the basket on wheels. The DON and RRN confirmed the piece of unbagged contaminated linen should be bagged and in the dirty linen utility room . The DON stated the NA's are responsible for keeping the laundry rooms clean. The RRN confirmed the laundry room smelled wet like mildew and the DON had donned gloves to put the contaminated sheet in a plastic bag, placed in the soiled utility room returned to tidy up. During an interview on 2/27/25 at 9:43 a.m., the infection preventionist (IP) stated facility soiled linens (bed clothes, towels, wash cloths, incontinence pads) are bagged at point of care and taken to the soiled utility room at the end of each hall. Soiled linens are outsourced for washing. Resident's personal laundry is stored in baskets in the resident's room and then taken to the laundry room on each unit for washing.	F 880	be conducted by the Director of Nursing or Designee three times a week for two weeks, then two times a week for two weeks, then once a week for two weeks. Audit results will be reported at the monthly Facility Quality Council meeting on April 15th, 2025 to determine if continued auditing or further corrective actions are necessary. If any deficiencies are identified, additional staff training and disciplinary action will be implemented as necessary.	

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F 880	Continued From page 5 Resident's laundry is washed one resident at a time. The IP stated there are times soiled facility linens get mixed up with the residents' personal clothing. IP confirmed all dirty linens/clothing to be kept separate from clean linen. A policy dated 5/15/24 stated dirty linens should be bagged at the point of use and kept separate from clean laundry and linens.	F 880		
F 908 SS=F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain kitchen equipment used to keep food warm prior to serving. Findings include: During an observation and interview on 2/24/25 at 1:47 p.m., culinary director (CD) was preparing the lunch meal and placing food into a hotbox (an insulated container for food storage). CD stated the food was kept in the hotbox until ready to go to each floor's kitchenette. The hotbox had a top and bottom compartment. There was a container of egg rolls in the top compartment of the hotbox to be served to the residents for dinner. The internal temperature of the bottom compartment read 156 degrees, the top compartment did not have an internal thermometer and an external display which read E00. CD was unable to provide clarification on what the E00 meant. CD	F 908	All culinary staff will be re-educated on Policy No: CS0601-Food Production Methods and Standards and Culinary Policy: Equipment Malfunction Policy by 3/27/25. Equipment was taken out of order on 2-25-25. The replacement part was ordered on 2-25-25. Equipment was fixed on 2-27-25. There were no residents or staff affected by the findings of the egg rolls. After the temperature of the egg rolls read 120F prior to serving, the food was removed by the CSS and heated to the correct temperature to 165F. This could have resulted in a food-borne illness if not taken care of right away. EVS will conduct a facility-wide audit of all kitchen equipment quarterly starting on	3/27/25

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 CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

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F 908	Continued From page 6 was uncertain of when the last time the hotbox was serviced. During an observation of second floor dining room on 2/24/25 at 5:09 p.m., dietary aid (DA-A) took temperatures of egg rolls with an internal reading of 120 degrees. Surveyor intervened and asked what the temperatures should be of foods being served to the residents. CD removed the egg rolls to rewarm prior to serving. During an interview on 2/25/25 at 9:01 a.m., CD reviewed the use of the hotbox and stated it is only used for 20-30 minutes prior delivering foods to kitchenettes. CD was unaware the machine was not working and could not provide an explanation off what the display E00 reading meant. CD was unaware of any maintenance on the hotbox or if serviced on a regular basis. CD stated the expectation would be to have a working thermometer for both the top and bottom compartments prior to usage. The staff were to be monitoring the temperatures of the items placed in the hotbox and the temperatures should have been logged. CD indicated improper food temperatures increased the risk of a food borne illness. CD explained when equipment is not working properly, staff were to notify the supervisor and/or maintenance to get the machine fixed. During an interview on 2/25/25 at 3:21 p.m., environmental services manager (ESM) stated he could not find a service slip or maintenance request since January. ESM mentioned, at one time there had been two of the hotboxes in the kitchen and used one to fix the current one but could not verify the timeframe on when this occurred.	F 908	3-26-25 and document findings. Any equipment failures will be logged and addressed immediately. EVS will put it in the auto reminder in the TELS system for the quarterly checks. Audit will be brought to QAPI. Audits will be maintained for 1 year. The Culinary Director/Culinary Supervisor will conduct spot checks on all kitchen equipment once a week for 6 months starting on 3-24-25/9-22-25. Findings will be recorded and equipment that is failing will be taken out of order and reported to EVS immediately using the TELS system. Audits will be maintained for 1 year and be reported to QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 02/27/2025

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
F 908	Continued From page 7 During an interview on 02/27/25 at 11:40 a.m., administrator stated being unaware of the equipment not working in the kitchen. Administrator explained the expectation would be if staff identify something wrong or broken, then the piece of equipment should be taken out of service until the department supervisor or maintenance could review and repair. Administrator verified there was a potential for foodborne illness if food was not held at correct temperatures. Maintenance logs and equipment information was asked for and not provided.	F 908		

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 _____	**02/25/2025**

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 000	INITIAL COMMENTS FIRE SAFETY - BLDG 01 An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/25/2025. At the time of this survey, ST CRISPIN LIVING COMMUNITY 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		03/20/2025

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 **01 - MAIN BUILDING 01** B. WING _____	**02/25/2025**

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 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	K 000		

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 _____	**02/25/2025**

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 000	Continued From page 2 building with a partial basement that was 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 58 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct	K 345	1. As response to the facility lacking documentation regarding sensitivity	3/19/25

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 _____	**02/25/2025**

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 345	Continued From page 3 sensitivity testing of the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.4.5.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/25/2025 between 09:30 AM and 2:30 PM, it was revealed by a review of available documentation that the documentation presented for review identified that the most recent fire alarm sensitivity testing was completed in 2022. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 345	testing of the fire alarm smoke detection system, an annual sensitivity test, and the detailed sensitivity test of the smoke detection system, a two-year requirement, the facility failed to provide evidence that the detailed smoke sensitivity test was conducted; a two-year requirement. 2. The facility will ensure that the proper sensitivity tests are conducted and that areas where the fire alarm systems are located are free from obstruction. All alarm system testing will be placed on a schedule to ensure the appropriate test are conducted are required. Once each test is conducted, the testing documentation will be placed in file. Access to the fire alarm systems will be monitored to ensure that areas are free obstruction. 3. All required testing will be placed on a schedule and will be scheduled in our TELS system. Any identified issues will be brought to QAPI. 4. The Environmental Services Director or designee will be responsible.	
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	K 353		3/19/25

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 _____	**02/25/2025**

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 353	Continued From page 4 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, a review of available documentation, and staff interview the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.3, 4.4, 5.1.1.1, 5.2.1.1.1, 5.2.1.1.2, 5.2.2.2, 13.3.2, 13.3.2.2(3) These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 02/25/2025 between 09:30 AM and 2:30 PM, it was revealed by observation in the Basement Corridor - Cross-over Area that a sprinkler head exhibited signs of paint or spackling debris. 2. On 02/25/2025 between 09:30 AM and 2:30 PM, it was revealed by observation that in the Basement - Electrical / Mechanical Room that external load was bearing of the sprinkler system - cabling zip-tied to the piping. 3. On 02/25/2025 between 09:30 AM and 2:30 PM, it was revealed a review of available	K 353	1. The facility failed to ensure the Automatic Sprinkler systems are meeting standards of the requirement. It was found that the sprinkler head located at the basement corridor-cross over area exhibited signs of paint and debris. The sprinkler head was replaced. Additionally, all cable zip ties were removed from the identified piping. 2. The facility will ensure that maintenance and inspection of all sprinkler head in the identified area are conducted in order to ensure that the sprinkler head free from paint and debris and also the piping identified to ensure that the piping is free from cable zip ties. 3. The EVS director will place a schedule in TELS in order to ensure that sprinkler heads in the area identified are inspected on a quarterly basis. And a schedule will be placed in the TELS system to inspect the identified piping is free from Zip Ties. Any identified issues will be brought to QAPI. 4. The Environmental Services Director or designee will be responsible.	

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K 353	Continued From page 5 documentation that no documentation was presented for review associated to the most recent 5-year maintenance and inspection. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview the facility failed to document corrective actions associated to door testing per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.15, and NFPA 80 (2010 edition), sections 5.2.1, 5.2.15. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/25/2025 between 09:30 AM and 2:30 PM,	K 761	1. The facility failed to provide the necessary annual inspection documentation that confirmed that the deficient practice was corrected regarding the smoke barrier doors. 2. The facility will ensure that the fire smoke barrier doors do not have a 1/8th inch gap on the areas identified. When the corrections to the doors are produced, the EVS director will document the correction. 3. Upon correction of the Smoke Barrier	3/28/25

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K 761	Continued From page 6 it was revealed by a review of available documentation that no documentation was presented for review to confirm that corrections had been completed associated to annual door inspections completed - August 28, 2024. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	doors located in Building 01, the corrections will be documented and the documentation will be audited every 3 months, or until substantial compliance is met and then annually. Any issues identified will be brought to QAPI. 4. The Environmental Services Director or designee will be responsible.	

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 _____	**02/25/2025**

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K 000	INITIAL COMMENTS FIRE SAFETY - BLDG 02 An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/25/2025. At the time of this survey, ST CRISPIN LIVING COMMUNITY 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 18 New 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		03/20/2025

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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	245449	A. BUILDING **02 - ST CRISPIN LIVING COMMUNITY** B. WING _____	**02/25/2025**

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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: 6. A detailed description of the corrective action taken or planned to correct the deficiency. 7. Address the measures that will be put in place to ensure the deficiency does not reoccur. 8. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 9. Identify who is responsible for the corrective actions and monitoring of compliance. 10. 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	K 000		

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 _____	**02/25/2025**

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K 000	Continued From page 2 building with a partial basement that was 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 58 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation and staff interview, the facility	K 345	1. As response to the facility lacking documentation regarding sensitivity	3/19/25

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 _____	**02/25/2025**

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K 345	Continued From page 3 failed to conduct sensitivity testing and provide unobstructed access to the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 18.3.4.1, 9.6.1.3, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 10.16.3.2, 14.4.5.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 02/25/2025 between 09:30 AM and 2:30 PM, it was revealed by a review of available documentation that the documentation presented for review identified that the most recent fire alarm sensitivity testing was completed in 2022. 2. On 02/25/2025 between 09:30 AM and 2:30 PM, it was revealed by observation in the 2nd Floor Laundry Room, that ready access to the Fire Alarm Panel room was obstructed. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 345	testing of the fire alarm smoke detection system, an annual sensitivity test, and the detailed sensitivity test of the smoke detection system, a two-year requirement, the facility failed to provide evidence that the detailed smoke sensitivity test was conducted; a two-year requirement. Secondly, the access to the fire alarm system was obstructed. All sensitivity testing requirements will be conducted and documented and all obstructions to the fire alarm panel will be removed. 2. The facility will ensure that the proper sensitivity tests are conducted and that areas where the fire alarm systems are located are free from obstruction. All alarm system testing will be placed on a schedule to ensure the appropriate test are conducted are required. Once each test is conducted, the testing documentation will be placed in file. Access to the fire alarm systems will be monitored to ensure that areas are free obstruction. 3. All required testing will be placed on a schedule and will be scheduled in our TELS system. Areas which have the potential to be obstructed located at or around fire alarm systems will be audited once a week for 4 weeks and then once a month or until we reach substantial compliance. Any identified issues will be brought to QAPI. 4. The Environmental Services Director or designee will be responsible.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		3/28/25

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 _____	**02/25/2025**

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 353	Continued From page 4 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, a review of available documentation, and staff interview the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.3, 4.4, 13.3.2, 13.3.2.2(3) These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 02/25/2025 between 09:30 AM and 2:30 PM, it was revealed by observation that the Sprinkler System Riser Room was access obstructed.	K 353	1. As response to the facility lacking documentation regarding the 5-year maintenance and inspection of the sprinkler system, a requirement that is to be done every 5 years, the facility failed to provide the necessary documentation that the test was conducted. As a result, the facility reached out to the vendor and made arraignments to receive a copy of the 5-year maintenance and inspection report in order to file. Once received, the facility will file the documentation. Secondly, the access to the sprinkler riser room were obstructed. All obstructions to the Sprinkler Riser Rooms will be removed. 2. The facility will ensure that the 5-year maintenance and inspection reports are	

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K 353	Continued From page 5 2. On 02/25/2025 between 09:30 AM and 2:30 PM, it was revealed a review of available documentation that no documentation was presented for review associated to the most recent 5-year maintenance and inspection. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	filed appropriately. Additionally, all accesses to the Sprinkler Riser Rooms will be monitored for obstructions. 3. The required 5-year testing will be placed on a schedule in TELS in order to ensure that the required 5-year test is conducted. Areas which have the potential to be obstructed located at or around the Sprinkler Riser Rooms will be audited once a week for 4 weeks and then once a month or until substantial compliance met. Any identified issues will be brought to QAPI. 4. The Environmental Services Director or designee will be responsible.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 NEW Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1-3/4 inch thick solid bonded core wood. Required clear widths are provided per 18.3.7.6(4) and (5). Nonrated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal-sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels, or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.6, 18.3.7.7, 18.3.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 374	1. As response to the smoke barrier door	3/28/25

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 _____	**02/25/2025**

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K 374	Continued From page 6 facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 18.3.7.8 and 8.5.4.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 02/25/2025 between 09:30 AM and 2:30 PM, it was revealed by observation that the following fire / smoke barrier door assemblies exhibited and air-gap greater that 1/8 inch, allowing the movement and passage of smoke: 2nd Floor - door assembly (47); 1st Floor - door assembly (21); 1st Floor - door assembly (32). An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 374	assemblies exhibiting an air gap greater than 1/8 of an inch, allowing the potential for the movement of smoke on 1st and 2nd floors, the doors will be modified to ensure that the 1/8 gaps do not exist. 2. The facility will ensure that the fire smoke barrier doors do not have a 1/8th inch gap on the areas identified. 3. The fire barrier doors in building 02 will be placed on a schedule to be monitored for fire compliance. The smoke barrier doors will be audited once every 3 months for the first year and then once annually. Any issues identified will be brought to QAPI. 4. The Environmental Services Director or designee will be responsible.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 18.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (NFPA 80) This REQUIREMENT is not met as evidenced	K 761		3/28/25

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K 761	Continued From page 7 by: Based on document review and staff interview the facility failed to document corrective actions associated to door testing per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.15, and NFPA 80 (2010 edition), sections 5.2.1, 5.2.15. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/25/2025 between 09:30 AM and 2:30 PM, it was revealed by a review of available documentation that no documentation was presented for review to confirm that corrections had been completed associated to annual door inspections completed - August 28, 2024. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	1. The facility failed to provide the necessary annual inspection documentation that confirmed that the deficient practice was corrected regarding the smoke barrier doors. 2. The facility will ensure that the fire smoke barrier doors do not have a 1/8th inch gap on the areas identified. When the corrections to the doors are produced, the EVS director will document the correction. 3. Upon correction of the Smoke Barrier doors located in Building 02, the corrections will be documented and the documentation will be audited every 3 months, or until substantial compliance is met and then annually. Any issues identified will be brought to QAPI. 4. The Environmental Services Director or designee will be responsible.	

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	00150	A. BUILDING: _____ B. WING _____	C 02/27/2025

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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: On 2/24/25 to 2/27/25 , 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	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H54498382C (MN00110900, MN00110779, MN00110901), H54493940C (MN00109467), H54498521C (MN00110885). NO citations were issued. 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.	2 000		

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2 000	Continued From page 2 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.	2 000		
21675	MN Rule 4658.1410 Linen Nursing home staff must handle, store, process, and transport linens so as to prevent the spread of infection according to the infection control program and policies as required by part 4658.0800. These laundering policies must comply with the manufacturer's instructions for the laundering equipment and products and include a wash formula addressing the time, temperature, water hardness, bleach, and final pH. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to properly bag and contain contaminated linen placed under a basket of clean resident laundry and maintain a clean laundry room used for resident personals. This had the potential to affect all 15 residents on the 300 unit. Findings include: During a tour of the 300-unit laundry room on 2/26/25 at 7:32 a.m., registered nurse (RN)-A stated dirty linens are bagged and put in the	21675	Corrected.	3/27/25

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21675	Continued From page 3 soiled utility room to be picked up by housekeeping staff on each unit and taken to the main utility room to be picked up by a contracted linen company. The process for resident clothing is completed by nursing assistant (NA)'s on resident's bath day. NA's bring resident's personal laundry to the unit laundry room, washes and dries the items and places them back in a basket on wheels. The basket on wheels is taken to the resident room to be folded or hung. The NA's used a dry erase board to communicate to other staff what residents' items are in each machine. The 300-unit laundry room had an unbagged yellow-stained contaminated bed sheet on the floor; with residents' clean personal laundry sitting in the basket on wheels above the contaminated linen. The floor of laundry room was dirty with used lint scraps under the sink and under basket on wheels. There was a used paper towel under the sink. Lint pieces were stuck to the white board and along floorboards. The detergent compartment on the washer was dirty with lint scraps and old soap. RN stated they used to use the pods for detergent but had recently switched to Ecolab products and the detergent was now completed with this system. The 300-laundry room smelled of wetness and mildew . During an interview on 2/26/25 at 7:22 a.m., maintenance (M)-A stated resident personal laundry is completed in the laundry rooms on each unit. M-A stated he does not collect dirty linens from unit laundry rooms. During an observation and interview on 2/26/25 at 8:30 a.m., NA-A stated it was the responsibility of the NA's to keep the unit laundry room tidy and clean. The wetness and mildew smell remained, the garbage remained, and the soiled bedsheet remained on the floor.	21675		

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21675	Continued From page 4 During an interview on 2/26/25 at 9:05 a.m., housekeeper (H)-A stated the NA's do the laundry and keep the laundry room clean. She does the housekeeping for the resident rooms and common areas. During an observation and interview on 2/26/25 at 10:24 a.m., director of nursing (DON) and regional registered nurse (RRN) viewed the 300-unit laundry room. RRN confirmed there is a yellow-stained unbagged dirty bed sheet sitting beneath resident clean laundry in the basket on wheels. The DON and RRN confirmed the piece of unbagged contaminated linen should be bagged and in the dirty linen utility room . The DON stated the NA's are responsible for keeping the laundry rooms clean. The RRN confirmed the laundry room smelled wet like mildew and the DON had donned gloves to put the contaminated sheet in a plastic bag, placed in the soiled utility room returned to tidy up. During an interview on 2/27/25 at 9:43 a.m., the infection preventionist (IP) stated facility soiled linens (bed clothes, towels, wash cloths, incontinence pads) are bagged at point of care and taken to the soiled utility room at the end of each hall. Soiled linens are outsourced for washing. Resident's personal laundry is stored in baskets in the resident's room and then taken to the laundry room on each unit for washing. Resident's laundry is washed one resident at a time. The IP stated there are times soiled facility linens get mixed up with the residents' personal clothing. IP confirmed all dirty linens/clothing to be kept separate from clean linen. A policy dated 5/15/24 stated dirty linens should be bagged at the point of use and kept separate	21675		

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21675	Continued From page 5 from clean laundry and linens. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures for proper infection control measures for linen handling and educate staff on those policies. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21675		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain kitchen equipment used to keep food warm prior to serving. Findings include: During an observation and interview on 2/24/25 at 1:47 p.m., culinary director (CD) was preparing the lunch meal and placing food into a hotbox (an insulated container for food storage). CD stated the food was kept in the hotbox until ready to go	21685	Corrected.	3/27/25

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21685	Continued From page 6 to each floor's kitchenette. The hotbox had a top and bottom compartment. There was a container of egg rolls in the top compartment of the hotbox to be served to the residents for dinner. The internal temperature of the bottom compartment read 156 degrees, the top compartment did not have an internal thermometer and an external display which read E00. CD was unable to provide clarification on what the E00 meant. CD was uncertain of when the last time the hotbox was serviced. During an observation of second floor dining room on 2/24/25 at 5:09 p.m., dietary aid (DA-A) took temperatures of egg rolls with an internal reading of 120 degrees. Surveyor intervened and asked what the temperatures should be of foods being served to the residents. CD removed the egg rolls to rewarm prior to serving. During an interview on 2/25/25 at 9:01 a.m., CD reviewed the use of the hotbox and stated it is only used for 20-30 minutes prior delivering foods to kitchenettes. CD was unaware the machine was not working and could not provide an explanation off what the display E00 reading meant. CD was unaware of any maintenance on the hotbox or if serviced on a regular basis. CD stated the expectation would be to have a working thermometer for both the top and bottom compartments prior to usage. The staff were to be monitoring the temperatures of the items placed in the hotbox and the temperatures should have been logged. CD indicated improper food temperatures increased the risk of a food borne illness. CD explained when equipment is not working properly, staff were to notify the supervisor and/or maintenance to get the machine fixed.	21685		

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21685	Continued From page 7 During an interview on 2/25/25 at 3:21 p.m., environmental services manager (ESM) stated he could not find a service slip or maintenance request since January. ESM mentioned, at one time there had been two of the hotboxes in the kitchen and used one to fix the current one but could not verify the timeframe on when this occurred. During an interview on 02/27/25 at 11:40 a.m., administrator stated being unaware of the equipment not working in the kitchen. Administrator explained the expectation would be if staff identify something wrong or broken, then the piece of equipment should be taken out of service until the department supervisor or maintenance could review and repair. Administrator verified there was a potential for foodborne illness if food was not held at correct temperatures. Maintenance logs and equipment information was asked for and not provided. SUGGESTED METHOD OF CORRECTION: The administrator, maintanice director or designee could develop, review, and/or revise policies and procedures to ensure equipment is kept in continuous state of good repair and operation. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		