Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 5, 2025

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

RE: CCN: 245484
Cycle Start Date: March 27, 2025

Dear Administrator:

On May 8, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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Electronically delivered
April 8, 2025

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

RE: CCN: 245484
Cycle Start Date: March 27, 2025

Dear Administrator:

On March 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:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245484	A. BUILDING _____ B. WING _____	03/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 3/24/25 to 3/27/25, 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 3/24/25 to 3/27/25, 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 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4)	F 585		5/5/25

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

Electronically Signed | 04/15/2025

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 585	Continued From page 1 §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right	F 585		

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F 585	Continued From page 2 to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance,	F 585		

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F 585	Continued From page 3 and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow through on a grievance regarding missing clothing for 1 of 1 resident (R9) reviewed for grievances. Findings include: R9's admission Minimum Data Set (MDS) dated 1/28/25, identified R9 had a severe cognitive impairment and diagnoses included Alzheimer's disease and dementia. During a phone interview on 3/24/25 at 3:07 p.m., family member (FM)-A stated half of R9's clothing and slippers were missing. The first thing staff asked FM-A was if FM-A labeled the clothing. FM-A stated she was unaware she needed to label the clothing prior to bringing it to the facility and was told to bring R9's clothing to the nurses' desk so that's what FM-A did. The clothing and slippers went missing from there. FM-A stated she had to re-buy all the missing items, was not reimbursed and would no longer allow R9's clothing to be washed at the facility.	F 585	During the survey process it was noted that the facility failed to follow through on a grievance regarding missing clothing for 1 of 1 residents. The facility failed to have a clear process in place for managing reports of missing items to ensure unresolved issues are managed, escalated and addressed as a grievance. Social services reached out to the representative for R9. Family did not want to file a grievance. The facility is still in the process of searching for the newly missed placed items. Family voiced appreciation of actions taken, the new process and follow up communication. All residents have the ability to be affected by this deficient practice. We followed up with all residents that have recently reported any missing items to ensure the appropriate actions were taken to locate or offer replacement of any missing items. Also, 20% of our current residents were	

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F 585	Continued From page 4 During an interview on 3/27/25 at 11:05 a.m., licensed practical nurse (LPN)-B stated FM-A did report R9 had missing clothing. LPN-B called the laundry and asked that laundry staff look for the missing items, but they were not found. FM-A stated she would wash R9's clothing from then on. LPN-B had never heard of anyone ever making a report or anything for missing items. During an interview on 3/27/25 at 11:07 a.m., registered nurse (RN)-E stated when a resident or family member reported missing items. Staff should start looking for it and report it to the social worker or the unit manager. For clothing, staff notified laundry and housekeeping, so everyone was looking for the missing item. Also, there was a rack of unlabeled clothing that they can look through and usually the missing item is found. During an interview on 3/27/25 at 11:47 a.m., the social services (SS)-A stated staff usually contacted SS-A or send an email to all staff so the item could be searched for. Then, SS-A went to laundry and/or took the family member or resident to the laundry to look through the lost and found to see if the item could be found. SS-A did not necessarily fill out a grievance form. SS-A would ask the resident or family member if they wanted to file a grievance, but they usually say they just want to keep an eye out for it. SS-A stated she was aware R9 had some missing clothing items. SS-A brought FM-A to the laundry to look through the lost and found and some items were found, and some items weren't. FM-A had given the clothing to a nurse who said they were bringing the clothing to laundry to get labeled, but the items went missing from there. SS-A did not fill out a grievance for R9.	F 585	randomly chosen and interviewed about missing items and the process to report concerns to identify if any other residents have been affected by the practice. The audit was completed, it was identified proper steps have been taken for those residents that reported missing items. R9 is the only resident affected by the practice. Facility policy on missing items and grievances were reviewed on 4/9/25. Revisions made to the missing items protocol. Staff will continue to send out an email to alert all Benedictine employees of a missing items and activate an internal search t/o the building. A process has been added to indicate the social workers will be the individuals responsible to manage the process. Once an item is identified as missing, the information will be added to our customer concern application to assist with tracking the process. The social workers will also communicate with resident or their representative throughout the process and report the findings to the facility Executive Director. Education will be provided to all personnel on the importance of timely notification of missing items. The facility social workers have been educated on the process changes. Education for all licensed staff, SS and ED will be completed by May 2nd, 2025 To ensure compliance; an audit on resident missing items will be conducted by the ED and/or designee on all resident	

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F 585	Continued From page 5 During an interview on 3/27/25 at 1:29 p.m., the director of nursing (DON) stated missing items was an area where the facility had room to improve. Usually, an email was sent out for all staff that indicated what was missing and staff responded with what was or wasn't found. The DON's understanding was the social worker brought that information to the administration or, at least, reached out to the family with how the family wanted to proceed. Usually, the administration instructed to replace those items, bring the receipt and the administration would reimburse those funds. The DON stated there was no documentation to show that was done for R9 and/or FM-A. All missing items are personal to the residents and staff needed to do their due diligence to find those items or to see if there was a pattern in a specific area. It was important to the residents and staff needed to be mindful of that. The facility Missing Items policy reviewed 8/4/17, identified the following: 1. All personal were responsible for reporting missing items to the supervisor staff prior to their end of shift. 2. Any items found that could not be identified, were reported to the supervisory staff and stored until the owner could be determined. 3. Staff worked to locate the missing items. 4. If items were not located, staff worked with the resident or resident representative to determine next steps.	F 585	missing items reported to ensure appropriate steps are taken. All resident missing items will be audited as they occur for 4 months and prn and/or as determined by quality council based on continued compliance. Audit results will be reviewed by quality council for monitoring and assured compliance. Facility will achieve substantial compliance by May 5, 2025.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs.	F 758		5/5/25

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F 758	Continued From page 6 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and	F 758		

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F 758	Continued From page 7 indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure use of an as-needed (PRN) psychotropic medication was limited to a 14-day period and/or obtain justification for continued use by the provide for 1 of 5 residents (R68) reviewed for unnecessary medication use. Findings include: R68's significant change Minimum Data Set (MDS) dated 2/3/25, identified R68 had severe cognitive impairment and did not exhibit behaviors during the assessment period. Diagnoses included Alzheimer's disease, dementia and bipolar disorder. R68's undated prescription fax request identified an order for diazepam 5 mg/ml liquid concentrate; administer 2.5 mg oral every 6 hours - PRN for anxiety/agitation, start date 2/19/25. The order failed to identify a justification of use beyond 14 days and did not provide an end date and/or re-evaluation date. R68's Medication Administration Record (MAR) dated 2/1/25 through 2/28/25, identified R68 received diazepam on 2/20/25, 2/23/35 (two doses), 2/25/25 and 2/28/25. R68's MAR dated 3/1/25 through 3/27/25,	F 758	During the survey process it was noted that the facility failed to ensure use of an as needed (PRN) psychotropic medication was limited to a 14-day period and or obtained justification for continued use from the provider for 1 of 5 residents. The facility failed to have a clear process in place to ensure compliance meeting the time constraint. Hospice was contacted, new orders received on 3/28/25 to continue Diazepam 2.5mg Q 6hrs PRN x 14 days for anxiety. Resident was reassessed on 4/10/25, orders received to hold oral meds and start Lorazepam 2mg, 0.5mg buccally Q 3 hrs PRN x 14 days for anxiety/restlessness. Plan to reassess with hospice provider by 4/24/25. All residents receiving a (PRN) psychotropic medication have the ability to be affected by this deficient practice. All residents have been audited to ensure proper steps have been taken for any and all resident affected by the practice. Full house audit revealed that no other residents were affected by this practice. Facility policy on Psychotropic medication	

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F 758	Continued From page 8 identified R68 received diazepam on 3/3/25. R68's medical record failed to identify a justification of continued use past the initial 14 days and failed to provide an end date for use and/or re-evaluation date. R68's Medication Regimen Review (MRR) dated 3/5/25, identified the consulting pharmacist recommended either discontinuing PRN use of diazepam for R68, or reorder for a specific number of days, per federal guidelines. On 3/27/25 at 11:13 a.m., registered nurse (RN)-D stated PRN psychotropic orders, including diazepam, were ordered by the provider for 14 days or required an end date with a rationale for use. RN-D stated R68's diazepam order did not have an end date or a rationale for use longer than 14 days and the order should've been discontinued until discussed with the provider. On 3/27/25 at 11:45 a.m., the director of nursing (DON) stated the nurses were aware if a PRN psychotropic order did not include an end date it was their responsibility to reach out to the provider. The order should also include a rationale for use if the provider ordered the medication for longer than 14 days, including orders for residents on hospice. On 3/27/25 at 1:16 p.m., the consulting pharmacist (CP) stated medication regimen review were completed on every resident on a monthly basis. PRN psychotropic medications required an end date of 14 days and/or a documented rationale for a longer period with an end date.	F 758	use policy was reviewed on 4/9/25 and no revisions made. Education will be provided to ensure all licensed staff are aware that PRN psychotropic medications require a 14-day end date until the provider documents justification for extended use. The interim and monthly pharmacy reviews will identify any misses, the DON or their designee will communicate directly with the appropriate Unit Manager to ensure pharmacy recommendations involving PRN psychotropic medications are addressed within the appropriate timeframe. The DON or their designee will provide direct supervision of the process and report to the pharmacy consultant, PCP and or medical director as needed. Education will be provided to all licensed nursing staff of the (PRN) psychotropic medication requirement limit of 14-day period and or need to obtained justification for continued use from the provider by May 2nd, 2025. Except as provided in 483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extend beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. The DON and their designee have been educated on the regulation and will provide direct supervision of the process. Education for all licensed staff, DON and Executive Director by May 2nd, 2025. To ensure sustained compliance; an audit	

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F 758	Continued From page 9 On 3/27/25 at 1:31 p.m., a message was left for the hospice provider. The undated Psychotropic Medication Use policy (POL_NS712) identified psychotropic medication are given upon a medical provider order. PRN orders for psychotropic drugs are limited to 14 days. PRN anti-psychotic orders are limited to 14 days and cannot be renewed unless the attending provider evaluated the resident for the appropriateness of that medication.	F 758	will be conducted by the DON or their designee on all resident receiving (PRN) psychotropic medications. All (PRN) psychotropic medications will be audited monthly for 4 months and prn and/or as determined by quality council based on continued compliance. Audit results will be reviewed by quality council for monitoring and assured compliance. The DON is responsible for compliance. Facility will achieve substantial compliance by MAY 5TH, 2025.	
F 880 SS=F	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;	F 880		5/5/25

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F 880	Continued From page 10 §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; (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.	F 880		

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F 880	Continued From page 11 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 document review, the facility failed ensure their infection control surveillance contained all data to effectively track, trend, analyze infections with the potential to affect all residents residing in the facility; and the facility failed to ensure enhanced barrier precautions and standard precautions for 1 of 2 residents (R140) reviewed for wound care; and failed to ensure contact precautions were followed for 1 of 3 residents (R75) reviewed for transmission-based precautions. Findings include: Surveillance: The Infection Prevention Line Listing dated March 2025, identified columns labeled the following: all units, ID number, resident name, age, sex, room, infection site, date/lab pathogen, date/symptoms, predisposing factors, date isolation began, date isolation ended, date/treatment, appropriate yes/no, in-house acquired, resolved yes/no. However, the line listing identified twelve resident names, age, sex and room number but failed to identify any other information. The Infections excel spreadsheet dated 3/4/25 to 3/20/25, identified the following: Two carbuncles (Norovirus infection can cause severe vomiting and diarrhea that start suddenly. Noroviruses are highly contagious. They commonly spread through food or water that is contaminated during preparation or through contaminated surfaces. Noroviruses can also spread through close	F 880	During the survey process it was noted that the facility failed to ensure our infection control surveillance contained all data to effectively track, trend, analyze infections with the potential to affect all residents residing in the facility. The facility failed to ensure enhanced barrier precautions and standard precautions were followed for 1 of 2 residents. And the facility failed to ensure contact precautions were followed for 1 of 3 residents. The facility failed to have a clear process in place to identify and track all potential communicable diseases. The facility failed to ensure associates had a clear understanding of the precaution requirements. R21 was discharged to the hospital on 3/4/25. R75□s line listings were updated to reflect the necessary infection control tracking for their signs and symptoms and treatment during their illness period in the timeframe from 3/4/2025 to 3/20/2025. R75 is no longer on precautions as norovirus has resolved. R 140 remains on EBP and has the necessary PPE and signage outside their door, care plan has been updated. All residents have the ability to be affected by this deficient practice. Surveillance audit, random chart reviews were completed on 20% of current residents that were not logged on the facilities IDT	

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F 880	Continued From page 12 contact with a person who has norovirus infection.) - 8 UTIs. - 1 septic arthritis - 1 bronchitis - 2 respiratory infections - 1 pneumonia All listed were treated with medication. R21: R21's admission Minimum Data Set (MDS) dated 2/11/25, identified R21 was cognitively intact and had diagnoses that included irregular heart rate, left femur fracture, fibromyalgia, left arm fracture, and right wrist fracture. R21 was frequently incontinent of bladder and had a colostomy (a surgical procedure that creates an opening for the colon through the abdominal wall. It is done when there is a problem with the colon or a disease affecting it). R21's nursing progress notes on 3/01/25 at 10:38 a.m., R21 was complaining of being weak, tired, nauseated, diarrhea, stomach pains. R21 was having the dry heaves. Colostomy bag was emptied. Toileted and put in bed per her request. R21 did try to eat oatmeal but that wasn't what she wanted or worked with her stomach. Has refused her morning medications. During an interview on 3/25/25 at 5:01 p.m., licensed practical nurse (LPN)-B stated that weekend R21 complained of diarrhea, abdominal pain and a low-grade temperature. Staff treated it like it was norovirus (Norovirus infection can cause severe vomiting and diarrhea that start suddenly. Noroviruses are highly contagious. They commonly spread through food or water	F 880	infection spreadsheet for possible changes in health status in the past month to identify if other residents have been affected. An audit has been conducted on all shifts, monitoring all residents currently on precautions, just in time education was provided during the audit process for any noncompliance. Facility policies on hand hygiene, enhanced barrier, contact & transmission-based precautions have been reviewed on 4/9/25 and no revisions made. We have updated the facility precaution signs to clearly inform staff of the specific requirements needed with regards to each precaution. All potential contagious signs and symptoms as well as infections will be tracked and discussed week days during IDT. The facility IP nurse will effectively track, trend, analyze infections with the potential to affect all residents residing in the facility. The IP nurse or their designee will provide education and direct supervision of the process, reporting any non-compliance regarding the use of precaution requirements to the appropriate supervisor. Education will be provided to all personnel on the importance of understanding and following precaution requirements. The IP nurse and their designee have been educated on the process of surveillance of logging all signs & symptoms of potential contagious symptoms/illness to track, trend, analyze. Education for all licensed staff, DON and Executive Director by May	

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F 880	Continued From page 13 that is contaminated during preparation or through contaminated surfaces. Noroviruses can also spread through close contact with a person who has norovirus infection.) The first day R21's diarrhea was frequent; sometimes every hour with some watery and some formed feces. R75: R75 discharge return anticipated MDS dated 3/14/25, identified R75 had a mild cognitive impairment and had diagnoses that included traumatic head injury and chronic obstructive pulmonary disease (COPD). R75 was frequently incontinent of bladder and bowel. R75 required substantial to maximum assistance with toileting. R75's nursing progress note dated 3/21/25 at 4:59 p.m., identified R75 returned to the facility after a hospitalization. R75 had been admitted to the hospital on 3/14/25 due to right lower lobe pneumonia and a complicated urinary tract infection (UTI). R75 tested positive for norovirus on 3/20/25 due to diarrhea. Contact precautions were initiated. The Infection Prevention Line Listing dated March 2025 and The Infections excel spreadsheet dated 3/4/25 to 3/20/25 , failed to identify R21 nor R75's symptoms and treatments. During an interview on 3/26/25 at 2:36 p.m., registered nurse (RN)-A stated she was the facility's infection prevention nurse as well as the Station 240-unit manager. RN-A dedicated eight hours a week to the infection prevention program but tried to keep up with infection signs/symptoms surveillance daily. The facility used an excel spreadsheet where any licensed staff could enter	F 880	2, 2025. To ensure compliance; an audit on surveillance of logging all signs & symptoms of potential contagious symptoms/illness to track, trend, analyze data. Additional audits will be conducted on resident with precautions. Audits will be conducted by the DON or their designee, they will occur for 4 months and prn and/or as determined by quality council based on continued compliance. Audit results will be reviewed by quality council for monitoring and assured compliance. The DON is responsible for compliance. Facility will achieve substantial compliance by May 5, 2025.	

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F 880	Continued From page 14 information when a resident was started on an antibiotic or antiviral. From there, RN-A would enter that information on the line listing form and do mapping of the infections at the end of the month. Additionally, the unit managers would read nursing progress notes daily to look for signs of infection. RN-A stated she was unaware of R21's symptoms but staff were generally aware of residents with symptoms such as nausea, vomiting and/or diarrhea. Rarely would the facility have a diagnosis correlating to the symptoms unless there were laboratory tests to confirm it. However, unless a resident was prescribed a treatment, such as antibiotics, the resident would not be added to the surveillance. During an interview on 3/27/25 at 12:09 p.m., the director of Nursing (DON) stated all signs and symptoms of potential infections should be tracked and evaluated timely to find trends earlier to try to prevent the spread of infection and keep it contained. The facility policy Surveillance Reporting revised 8/2023, identified once surveillance was completed, the data was collected and analyzed, and the significance was summarized. The resulting information should be shared with those who assist in the infection prevention and may include internal and external sources. 1. The IP performs on-going surveillance and investigation into all infections within the facility. 2. Once the surveillance is completed, the data collected is analyzed and summarized. It is then shared with the parties that assist with infection prevention in facilities, or if indicated external agencies. 3. If infection trends are noted, or there has been a break in infection prevention standards, the 1P	F 880		

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F 880	Continued From page 15 will educate the associates noted in the trend or break, put an action plan in place to monitor for adherence lo standards, and report the results of both the trend and/or break in standards, as well as the action plan to tile Quality Council for further recommendations/comments. 4. Internal reporting may include, but is not limited to: a. Resident and /or their significant support systems and family members b. Nursing c. Admitting d. Therapy e. Life enrichment/activities f. Environmental Services g. Maintenance h. Culinary i. Administration j. Quality Council 6. The IP must know what to report, how to report, and who must be informed. 7. Repo11ing requirements vary by state and may include reporting healthcare associated infections, community-associated infections, and infectious/communicable diseases. 8. As part of public reporting, each IP will make contact with the public health professionals who may assist the facility in time or need. Enhanced Barrier and Standard Precautions: R140 R140's admission MDS dated 3/19/25, identified R140 was cognitively aware and had diagnoses included osteomyelitis of sacral and sacrococcygeal vertebra (a rare infection in your spine. It happens when bacteria or fungi infect your vertebrae (spine bones). The infection can	F 880		

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F 880	Continued From page 16 start in your spine if the germs get in a wound or surgery site. It can also spread to your spine from somewhere else in your body. You'll need medication for several weeks to kill the infection. Vertebral osteomyelitis can damage your affected vertebra and the tissue around it in your spine.), type 2 diabetes, chronic kidney disease and weakness. R140 was at risk for pressure ulcers and had one stage 4 pressure ulcer. R140's care plan revised 3/13/25, identified R140 was at risk for alteration of skin status due to weakness, pain, type 2 diabetes and current treatment for osteomyelitis. Interventions included a special mattress, offloading when in bed, barrier cream applied to dry areas as needed, and a wheelchair cushion. R140 require a wound care treatment plan as follows: wound vac per orders and wet to dry dressings as needed. However, the care plan failed to identify R140's need for enhanced barrier precautions. R140's physician order dated 3/22/25, identified R140 had a wound vac to sacrum, change Tuesday, Thursday and Saturday and pressure set to -125. During an interview on 3/24/25 at 4:35 p.m., R140 stated he had a sore on his "butt" that was "awful". R140 stated the wound went "all the way to the bone" and the nurses were not really trained in how they take care of it. R140 had to direct staff, or staff got to a point and would have to start over. During an observation on 3/25/25 at 9:41 a.m., R140's door to his room had an enhanced barrier precautions (EBP) sign on his door with a personal protective equipment cart outside his	F 880		

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F 880	Continued From page 17 room. RN-B changed R140's wound vac dressing while licensed practical nurse (LPN)-A assisted. Prior to starting the dressing change RN-B and LPN-A entered R140's room without putting on a gown. Without gloves, RN-B removed R140's catheter bag from under R140's wheelchair and placed it on R140's bed frame. - At 9:43 a.m., LPN-A placed R140's walker in front of R140. With verbal cues and stand by assistance, R140 stood, turned and sat on his bed. - 9:45 a.m., RN-B nor LPN-A put on a gown. RN-B placed R140's wound vac on bed and removed the wound vac cover. RN-B put on gloves then clamped and disconnected the wound vac tubing. RN-B and LPN-A assisted R140 to pull down his pants. - 9:49 a.m., RN-B removed R140's soiled dressing. RN-B stated the dressing had bloody, brown drainage. RN-B removed her gloves, but did not use hand sanitizer before putting on new gloves and pulled foam from R140's wound. RN-B removed her gloves, but did not use hand sanitizer before putting on new gloves and cleansed the wound with a 4 inch by 4 inch gauze and wound cleanser. RN-B stated the wound was 25% slough (Slough in wound healing refers to dead tissue within a wound, often appearing as a yellow, tan, or white fibrous material) with some granulation (Granulation tissue heals the wound by filling in the wound from the base, moving upward) and a new undermined(caused by erosion under the wound edges, resulting in a large wound with a small opening) area. - 9:52 a.m., RN-B put on new gloves without using hand sanitizer and a portable electronic tablet to take photos of R140's wound, LPN-A used a gloved hand to pull back R140's right buttock to allow for a clear wound photo. RN-B	F 880		

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F 880	Continued From page 18 was leaning on R140's bed with the linens touching RN-B's forearms and the front of RN-B's uniform. RN-B removed her soiled gloves but did not use hand sanitizer and used a clipboard and pen to write down R140's wound measurements. - 9:54 a.m., RN-B opened the new wound vac dressing and laid it on R140's bed. RN-B did not place a clean surface for the dressing to lie on. - 9:55 a.m., RN-B put on clean gloves and replaced R140's wound vac dressing. RN-B nor LPN-A wore a gown and hand sanitizer was not used between soiled and clean gloves. - 10:18 a.m., RN-C entered R140's room without a gown or gloves, looked at R140's wound dressing and left the room. RN-B disposed of the dressing packaging, removed her soiled gloves and fastened R140's incontinence brief. RN-B and LPN-A assisted R140 to pull up his pants. - 10:22 a.m., RN-B and LPN-A exited R140's room. RN-B took the electronic tablet, clipboard and pen without using a sanitizing wipe. During an interview on 3/25/25 at 10:29 a.m., LPN-A stated R140's EBP were only for catheter/ostomy care. Staff did not need to wear a gown any other time. During an interview on 3/25/25 at 10:29 a.m., RN-B stated R140's EBP were for catheter cares and not for the wound care because R140 had a wound vac. RN-B stated gowns should be worn during wound care "yea, probably". During an interview on 3/25/25 at 10:29 a.m., RN-C stated staff were expected to wear a gown and gloves when entering R140's room, to perform hand hygiene (hand washing or hand sanitizer) when removing soiled gloves and were expected to clean all equipment when exiting the	F 880		

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F 880	Continued From page 19 room to prevent potential infections. During an interview on 3/26/25 at 2:57 p.m., RN-A stated staff were educated that when a sign was on a resident's door and there was a PPE cart there, staff were expected to put on PPE. The facility even implemented reference cards for the staff name badge, so staff always had access to what was needed and when. RN-A could not say why staff did not wear the appropriate PPE during a wound vac change because "it just screams" the need for PPE. During an interview on 3/25/25 at 10:31 a.m., the DON stated staff were expected to put on a gown and gloves when entering R140's room, use hand sanitizer between clean and dirty gloves and either leave the equipment in the room or clean it when leaving the room to prevent possible infections. The facility policy Hand Hygiene revised 2/5/20, identified there are situations in nursing homes and assisted living which may lead to a higher rate of infectious disease than a person living in their own home. Therefore, associates in these settings have a special concern to prevent the spread of infection through proper hand hygiene. All associates are accountable including those not involved in direct care. Clean hands are the single most important factor to stop the spread of infection. Hand must be washed with soap and water when hands are visibly soiled, after skin contact with blood or body fluids and after exposure to infectious materials. The CDC dated 6/28/24, identified Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 20 multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). The facility policy Enhanced Barrier Precautions undated, identified Enhanced Barrier Precautions (EBP) is a strategy in nursing homes to decrease transmission of CDC-targeted and other epidemiological important multidrug-resistant organisms (MDROs). EBP will be used for residents actively infected or colonized with CDC-targeted and other epidemiologically important MDROs. Additionally, residents at risk for MDROs, specifically those with an indwelling medical device and/or chronic wounds requiring a dressing will be required to use EBP. Transmission Based Precautions Centers for Disease Control and Prevention (CDC) Appendix A: Type and Duration of Precautions Recommended for Selected Infections and Conditions updated 2/7/25, identified norovirus required the use of contact precautions for a minimum of 48 hours after the resolution of symptoms or to control institutional outbreaks. Persons who clean areas heavily contaminated with feces or vomitus may benefit from wearing masks since virus can be aerosolized from these body substances; ensure consistent environmental cleaning and disinfection with focus on restrooms even when apparently unsoiled. Hypochlorite (Common examples include sodium hypochlorite	F 880		

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	245484	A. BUILDING _____ B. WING _____	03/27/2025

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F 880	Continued From page 21 (household bleach) and calcium hypochlorite (a component of bleaching powder, swimming pool "chlorine") solutions may be required when there is continued transmission. Alcohol is less active, but there is no evidence that alcohol antiseptic handrubs are not effective for hand decontamination. R75 R75 discharge return anticipated MDS dated 3/14/25, identified R75 had a mild cognitive impairment and had diagnoses that included traumatic head injury and chronic obstructive pulmonary disease (COPD). R75 was frequently incontinent of bladder and bowel. R75 required substantial to maximum assistance with toileting. R75's nursing progress note dated 3/21/25 at 4:59 p.m., identified R75 returned to the facility after a hospitalization. R75 was admitted to the hospital on 3/14/25 due to right lower lobe pneumonia and a complicated urinary tract infection (UTI). R75 tested positive for norovirus on 3/20/25 due to diarrhea. Contact precautions were initiated. R75's care plan revised 3/21/25, failed to identify R75's need for contact precautions. During an observation on 3/25/25 at 10:44 a.m., R75 was sitting in his wheelchair in his room. There was a contact precautions sign and PPE cart outside R75's room. Housekeeping (HK)-A entered R75's room with a hand-held basket with cleaning supplies. HK-A put on a pair of gloves but did not put on a mask or gown. HK-A cleaned R75's bathroom. High touch areas of R75's room and swept/mopped the floor.	F 880		

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F 880	Continued From page 22 During an interview on 3/25/25 at 11:05 a.m., HK-A stated R75 was on contact precautions but that was only for cares, when "staff had to touch R75." During an interview on 3/26/25 at 2:57 p.m., RN-A stated staff were educated that when a sign was on a resident's door and there was a PPE cart there, staff were expected to put on PPE. The facility even implemented reference cards for the staff name badge, so staff always had access to what was needed and when. When RN-A observed housekeeping not following precautions, RN-A educate them. RN-A stated housekeeping should have cleaned R75's room last and should have worn PPE while doing so. During an interview on 03/25/25 12:09 a.m., the DON stated housekeeping staff were expected to follow contact precautions while cleaning a room to prevent the potential transmission of infection. The facility policy Environmental Services - Cleaning dated 2020, identified the following: 1. Standard cleaning procedures will be used in isolation rooms; however, isolation rooms will be cleaned last or the equipment and water changed before going into another room to clean. 2. Special attention will be paid to cleaning of environmental surfaces in the isolation room, as these surfaces are frequent sources of person-to-person transmission of infection. 3. If mop and bucket solution are contaminated with feces or bloody fluids, they will be changed. 4. Appropriate personal protective equipment (PPE) will be worn: a. Contact precautions - Gloves and gown will be worn when in the room	F 880		

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F 880	Continued From page 23 - Must be removed with proper hand hygiene performed before leaving the room.	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/25/2025. At the time of this survey, Villa St. Vincent was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/16/2025

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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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

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

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K 000	Continued From page 2 building, is separated with a 2-hour fire barrier, does not have a basement and was determined to be Type II(111) construction. In 2003 a 1-story addition was constructed to the south of the original building, does not have a basement and was determined to be a Type II (000) construction and is not separated from the original building. The building is divided into 5 smoke zones with 2-hour and 1-hour fire rated barriers. The facility is protected with a complete automatic sprinkler system and also has a fire alarm system with corridor smoke detection and smoke detectors in all common areas that is monitored for automatic fire department notification. The facility has a capacity of 104 beds and had a census of 90 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or	K 324		5/5/25

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K 324	Continued From page 3 * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and inspect the kitchen hood ventilation and fire suppression system per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3 and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 03/25/2025, between 9;00am and 12:00pm,it was revealed by a review of available documentation that inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed test/inspection documentation for both of the semi-annual kitchen hood suppression system inspections for the last 12 months. An interview with the Maintenance Director	K 324	Our kitchen system inspection is done by Summit Fire Protection. Our Ansul system was inspected on; 12/04/2024, 07/04/2024, 02/27/2024, and 08/17/2023 by a technician from Summit Fire Protection. Further, our kitchen hood system was cleaned on: 03/05/2025, 9/26/2024, 05/02/2024, and 09/27/2023 by Hood Cleaners Company. A high priority work order as been generated by Summit Fire Protection to conduct the next inspection. The same is true for the Hood Cleaning Company, both companies are scheduled on a six month rotation. Follow up to ensure timely inspection will be done by Maintenance Supervisor.	

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K 324	Continued From page 4 verified this deficient finding at the time of discovery.	K 324		
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to implement a fire evacuation plan per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/25/2025, between 9;00am and 12:00pm, it was revealed by a review of available documentation that the facility could not provide a copy of an Out of Service Policy indicating that the facility would contact the State Fire Marshals Office (Authority having jurisdiction) in the event on a fire alarm outage lasting longer than four (4) hours in a 24-hour period, the policy is missing names and phone numbers for the AHJ. An interview with the Maintenance Director verified this deficient finding at the time of	K 346	Policies have been updated to reflect the proper contact information.	5/5/25

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K 346	Continued From page 5 discovery.	K 346		
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 a review of the available documentation and staff interview, the facility failed to implement a fire evacuation plan per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/25/2025, between 9;00am and 12:00pm, it was revealed by a review of available documentation that the facility could not provide a	K 353	Summit Fire Protection Company has provided the 4th Quarter Sprinkler Inspection dated 11/05/2024. The next annual sprinkler inspection will be conducted on Thursday April 17, 2025 by Summit Fire Protection Company.	5/5/25

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K 353	Continued From page 6 copy of an Out of Service Policy indicating that the facility would contact the State Fire Marshals Office (Authority having jurisdiction) in the event on a fire alarm outage lasting longer than four (4) hours in a 24-hour period, the policy is missing names and phone numbers for the AHJ. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353		
K 354 SS=D	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility did not properly implement a fire watch protocol for when the fire alarm system is out of service for more than 10 hours in a 24-hour period, according to NFPA 101 2012 edition, Life Safety Code, section 19.3.5.1, 9.7.5, and NFPA 25 2017 edition, Installation, Test and Maintenance of Water Based System, section	K 354	Policies have been updated to reflect the proper contact information.	5/5/25

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K 354	Continued From page 7 15.5.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/25/2025, between 0900am and 12:00pm, it was revealed by documentation review that the facility failed to provide an out of service policy that indicated that the facility would contact the State Fire Marshals Office (Authority having jurisdiction) in the event on a fire sprinkler system outage lasting longer than ten (10) hours in a 24-hour period. the policy is missing names and phone numbers for the AHJ. An interview with the Maintenance Manager verified these deficient findings at the time of discovery.	K 354		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per	K 712	Fire Drills will be spaced two hours apart from the previous quarters drill. For an example if the first quarter fire drill (for the	5/5/25

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K 712	Continued From page 8 NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 03/25/2025, between 9;00am and 12:00pm, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement: 1) First Shift, fourth quarter 2024, first quarter 2025 and second quarter 2025 all were within 1 hour of each other. 2) Second Shift, fourth quarter 2024, second quarter 2025, and third quarter all were within 30 mins. of each other. 3) Third Shift (NOC), fourth quarter 2024, first quarter 2025 and second quarter 2025 all were within 30 mins.of each other. 2. On 03/25/2025, between 9;00am and 12:00pm, it was revealed by a review of available documentation that fire drills were not completed: second shift missing first quarter (January - March) and third quarter (July - September) drills completely. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 712	overnight shift) is at 6:00 AM, the next drill will be at 4:00 AM.	
K 761 SS=D	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	K 761		5/5/25

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VILLA ST VINCENT	**516 WALSH STREET** **CROOKSTON, MN 56716**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 9 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 a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/25/2025, between 9;00am and 12:00pm, it was revealed by observation that the following fire doors and/or fire door frames were missing door rating tags. 1) Fire doors leading from therapy leading to chapel - missing tags on door frame An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	Life Safety Services (LSS) has been contracted and will be onsite on Tuesday April 29th, 2025 to appropriately label the fire door frame in question. An organized binder has bee created to hold the necessary documentation to verify this plan and will be audited on a monthly basis by the Maintenance Supervisor. Compliance with this plan be on or before May 5th, 2025	