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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: E7I5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00150

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245449**
2.STATE VENDOR OR MEDICAID NO.
(L2) **649240100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST CRISPIN LIVING COMMUNITY**
(L4) **213 PIONEER ROAD**
(L5) **RED WING, MN** (L6) **55066**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2012**

6. DATE OF SURVEY **07/20/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **64** (L18)
13.Total Certified Beds **64** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel ___ 6. Scope of Services Limit
___ 3. 24 Hour RN ___ 7. Medical Director
___ 4. 7-Day RN (Rural SNF) ___ 8. Patient Room Size
___ 5. Life Safety Code ___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	64			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Susie Haben, Unit Supervisor 07/24/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/24/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245449
July 23, 2018

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

Dear Mr. Goering:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective July 13, 2018 the above facility is certified for:

64 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 64 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 23, 2018

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

RE: Project Number S5449028

Dear Mr. Goering:

On June 14, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 23, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 20, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 23, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 13, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 23, 2018, effective July 13, 2018 and therefore remedies outlined in our letter to you dated June 14, 2018, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: E7I5

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(L3) **ST CRISPIN LIVING COMMUNITY**
(L4) **213 PIONEER ROAD**
(L5) **RED WING, MN** (L6) **55066**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2012**

6. DATE OF SURVEY **05/23/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
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04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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To (b) :

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13.Total Certified Beds **64** (L17)

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A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	64			
(L37)	(L38)	(L39)	(L42)	(L43)

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16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Mary Beth Lacina, HFE NE II 06/29/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/23/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
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____ 2. Facility is not Eligible
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23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
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28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 14, 2018

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

RE: Project Number S5449028

Please Note: Life Safety Code (LSC) survey finding will follow in a separate notice.

Dear Mr. Goering:

On May 23, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susie.haben@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 2, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 2, 2018, the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 August 23, 2018 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 23, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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 _____	05/23/2018

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 A survey for compliance with CMS Appendix Z, Emergency Preparedness Requirements, was conducted May 20, 2018 through May 23, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 5/20, 5/21, 5/22 and 5/23/18, a standard 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, and Requirements for Long Term Care Facilities. 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by:	F 554		7/13/18

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

Electronically Signed | 06/22/2018

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 _____	05/23/2018

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 554	Continued From page 1 Based on observation, interview and document review, the facility failed to determine whether the practice of self-administration of medications (SAM) was safe for 1 of 1 resident (R21) observed to self-administer a nebulizer (inhalent medication). Findings include: On 5/20/18 at 5:57 p.m., R21 was observed in his room with a face mask on receiving a nebulizer (neb) treatment. There was no staff present in the room. Trained medication aide (TMA) was outside the room on the other side of the hallway, and was not in a position to observe R21. At 6:13 p.m., TMA-A entered R21's room, turned off the machine, rinsed the machine in water and put the nebulizer machine away. Review of R21's Admission Record indicated R21 was admitted to the facility on 12/29/16, with diagnoses including: major depressive disorder, shortness of breath, anxiety disorder, hypertension and macular degeneration. R21's Physician's Order dated 10/30/17, included: albuterol sulfate Solution for nebulization two times a day and as needed every day, one time, for shortness of breath. A progress note from 12/22/17 at 8:23 a.m., read: "Annual Self-Administration of Medications assessment: Resident is unable to self-administer meds after set up. Resident is able to self-administer nebs after set up. Will continue current plan of care." Although the resident had been determined to be able to self administer the neb treatment, there was no physician involvement in the decision, and a 3/26/18 Brief	F 554	It is the policy of St. Crispin Living Community to follow all Federal, State, and local guidelines, laws and regulations and statutes. This plan of correction is not to be construed as an admission of deficient practice by the facility administrator, employees, agents, or other individuals. The response to the alleged deficient practice cited in this statement of deficiencies does not constitute agreement with citation. The preparations, submission and implementation of this plan of correction will serve as our credible allegation of compliance. TAG F554 R21 residents POC, orders, and SAM observation were reviewed. RN charted on 12/22/17 that Resident is able to self-administer nebs after set up. However, there was no order and care plan was not updated. Upon review with resident she declined to SAM nebulized treatments. TMA was counseled and re-educated on SAM policy and procedure. St. Crispin will continue to follow our policy and procedure to assess for the resident□s competency and ability to SAM upon admission and reassess with quarterly or significant change assessments. The IDT will discuss SAM during the initial care conference and obtain an MD order if resident is assessed as competent. To protect all other residents; DON or	

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 _____	05/23/2018

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 554	Continued From page 2 Interview for Mental Status (BIMS) assessment of R21's cognitive abilities, indicated R21 had severely impaired cognition. R21's care plan included a notation from 1/17/17, "Unable to self-administer medications". When an interviewed on 5/20/18 at 6:08 p.m., TMA-A verified R21 was self-administering an albuterol nebulizer even though the physician had not identified the resident could self administer it. TMA-A stated staff normally set up R21's nebulizer and leave the room while the nebulizer is administered. She state staff usually "check back in about 10 minutes and turn it off. It's a standard thing for this resident". During an interview on 5/20/18 at 6:15 p.m., R21 stated the staff normally setup the nebulizer, place it on R21's face and leave the room. R21stated it was very uncomfortable because staff forget to come back on time and the machine then runs for a long time. When interviewed on 5/20/18 at 6:40 p.m., the director of nursing (DON) verified R21 did not have an order from the physician for SAM. The DON stated if residents do not have SAM orders in place staff should not leave medications with the resident in any form for self-adminieration. The facility's policy Self Administration dated 12/2002 included: "Self-administered medications and treatments must be carefully monitored and recorded in the Medication Administration Record (MAR) and Treatment Administration record (TAR)". The policy further directed staff: "1. Residents are asked upon admission if they would like to self-administer their medications,	F 554	designee will review SAM policy and procedure with licensed staff and TMAs in the next nursing meetings on July 4th and 5th 2018. 4 medication pass audits will be completed weekly on all 3 shifts x 3 weeks to ensure nursing staff comply with this policy. The results will be presented to Quality Council for review for need for continued audits. The Alixa pharmacy consultant will continue with quarterly medication administration audits.	

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F 554	Continued From page 3 and their response is documented in their Medical Record. 2. The resident is assessed for competency and physical ability to self-administer medications. 3. A decision to permit self-administration is made by the Interdisciplinary team at the initial Care Conference, in concert with the resident. 4. The physician is notified of resident's desire and of facility assessment process. 5. The physician orders must include drug name, dosage, route, and any special instructions ..."	F 554		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accommodate resident preferences for personal furnishings for 3 of 3 residents reviewed (R36, R26 and R17) for environmental concerns. Findings include: According to the Admission Record, R36's most recent admission was 1/16/18, and R36 had diagnoses including quadriplegia and cancer. A quarterly Minimum Data Set (MDS) assessment dated 4/12/18, indicated R36 was cognitively intact. During an interview with R36 on 5/20/18 at 12:50	F 558	F558 R36 Dresser has been placed in resident□s room 6/22/18 and an extra tray table has been set up for resident□s computer. Resident has access to his computer and his Alexa is set up for his use. R26 request for an extra bedside dresser has been fulfilled on 6/22/18. R17 was provided a toilet riser on 5/20/18. Resident rights policy will be reviewed with all staff at monthly employee/administrator meetings	7/6/18

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F 558	Continued From page 4 p.m.. R36 stated when the nursing home had been relocated to their new building, the residents were not allowed to bring furnishings from the prior facility. R36 stated he had only been provided a wardrobe, but had no dresser for his clothing. R36 said he had requested a dresser but was told it may be a fire code issue but that they'd "look into it." R36 reported his request had been made approximately three weeks ago, shortly after moving to the new facility. During the interview, the surveyor observed three large boxes stacked against a wall on the left side of R36's room. R36 also stated he had requested to bring an extra tray table he'd been using for his computer to his new room, but said he'd been told he couldn't bring the table to the new facility even though the staff had not been provided an alternate table for his computer. R36 stated it was upsetting because working on his adaptable computer was one of the only things he could do independently and that was what he would typically choose to do for leisure. R36 again stated he'd asked the facility to provide a desk, table or tray table for his computer but had been told "no." R36's computer was observed in a box in the shower. During an interview with registered nurse (RN)-B on 5/23/18 at 10:45 a.m., RN-B stated he was aware R36 had requested a dresser and believed it had been ordered and should be here soon. However RN-B was unsure whether this had been relayed to R36, and also was unaware whether any alternate computer table provisions were being made. When asked how R36 generally spent his time, RN-B stated that over the last three months he'd mostly observed R36 visiting with his mother or working on his computer in his room. RN-B verified R36's	F 558	(Java-with-Jake). To protect other residents DON or designee will assess all residents in the facility for any further requests and to ensure all requests for needs have been addressed by 7/2/18 and then placed into the customer concern database. Any further resident requests will be brought to the attention of the administrator or designee during resident council, care conferences, etc. and placed into customer concern database for review. All staff have been educated on how and when to use the customer concern database. If a resident has a request or concern that can be placed into the database and assigned to the supervisor in charge of the aligning department for review and response. DON or designee will complete facility audit and ongoing accommodation of needs will be addressed at initial care conference upon admission and at least quarterly thereafter.	

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F 558	Continued From page 5	F 558		

computer had not been accessible since the move.

According to the admission record, R26's most recent admission was on 10/12/17, and R26 had diagnoses including chronic obstructive pulmonary disease and sleep apnea. A quarterly MDS dated 4/5/18, indicated R26 cognitively intact.

During an interview with R26 on 5/21/18 at 8:50 a.m., R26 stated she'd made a request for a small table to keep her CPAP (Continuous Positive Airway Pressure) machine (to treat her sleep apnea) on but was told "no". During interview, the CPAP mask and hose were observed to be on the floor. The CPAP machine was observed to be on a night stand along with a nebulizer machine. R26 additionally stated she had a small refrigerator at the previous facility and was told she could not bring it to the new facility because they were not going to allow those things here, "they told us we could not bring anything because they were providing everything." R26 continued by stating her kids bought a recliner that was very comfortable and was helpful to her back, but stated she'd been told she could not bring it to the new facility, "I complained in the beginning."

R17's admission record indicated an admission date of 3/1/17 with a primary diagnosis of heart failure. According to a quarterly MDS dated 3/6/18, R17 had fully intact cognition, but was dependent on staff for help with hygiene cares.

During an interview with R17 on 5/20/18 at 2:35 p.m., R17 stated she was having trouble getting off the toilet and had been waiting for a toilet riser

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F 558	Continued From page 6	F 558		

for three weeks. R17 stated she knew a lot of other residents were also waiting for toilet risers and stated she didn't understand why it would take so long.

While reviewing R17's record, a customer concern note dated 5/1/18 was identified. The concern indicated R17 had complained to staff she was having difficulty getting off her toilet because it was too low. The director of nursing (DON) was listed as the person responsible to follow up on the concern. According the documentation, the DON followed up on 5/8/18 and documented, "Toilet height is the same as Seminary Home." The corrective action was documented as, "Toilet riser requested will reassess when obtained."

During an interview with the social services director (SSD)-A on 5/23/18 at 11:23 a. m., SSD-A was asked how the facility was responding to furniture and equipment requests following the move to the new facility. SSD-A stated, "Some people wanted different furniture and that has been taken care of, some people wanted additional furniture in their rooms and that is on order." When asked specifically about toilet risers, SSD-A stated, "to my knowledge those should be fulfilled."

During interview with the DON on 5/23/18 at 12:47 p.m., the DON was asked about toilet risers. The DON stated, "I believe everyone who wanted one, received one." The DON also stated the toilets at this new facility were not any lower than at the previous facility, but leadership assumed the new placement of the support bars next to the toilet may be contributing to the toilets feeling lower.

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F 558	Continued From page 7 The administrator was interviewed on 5/23/18 at 1:55 p. m.. When asked about the communication with residents regarding previous furnishings/personal belongings and what they could bring to the new building, the administrator stated, "we strongly encouraged them to look at the new room and consider what furniture was being provided." When asked directly if they would allow a resident to bring in their own recliner, he stated, "we would, we have to because of resident rights, but we did say we would prefer they try to use the recliners that were provided and designed specifically for this building, they're good for staff and the facility walls." The administrator further stated they'd worked with a space planner. When asked about R36's requests, he stated he was aware of R36's request for a dresser. The administrator clarified that rooms with tracks (for full body lifts) were only furnished with a wardrobe and verified R36 was not happy with that. When asked about R36's additional request for a tray table or desk to put his computer on, the administrator stated he'd not been aware of that request. When asked about toilet risers, the administrator stated he believed all requests had been filled. The facility's policy, Resident Rights dated 11/28/16, included: "The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents....The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents."	F 558		

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F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide personal hygiene assistance for 1 of 2 residents (R14) assessed as being dependent upon staff for activities of daily living (ADL's); and failed to ensure 1 of 1 resident (R26) dependent on staff for ambulation, received assistance to ambulate. Findings include: On 5/20/18 at 1:20 p.m., R14 was observed to have several gray/white facial hairs on her upper lip and chin areas, which were approximately 1 inch long. In addition, R14's lower lip had sticky yellowish food crumbs stuck to the facial hairs. When asked if staff helped with shaving and feelings about having facial hair, R14 was unable to respond. At 6:54 p.m., R14 continued to have numerous long facial hairs and sticky yellow and red food clumps stuck to the chin hair while R14 was lying in bed. On 5/21/18 at 9:38 a.m., R14 was observed sitting up in a wheel chair in the lobby. The resident continued to have many long gray/white facial hairs to the upper lip and chin areas, which were approximately 1 inch long. On 5/22/18 at 10:26 a.m., R14 was observed lying in bed in her room. She continued to have long gray/white facial hairs to the upper lip and	F 677	F677 Resident R14 has been provided a razor by the facility, staff offered to shave her on the date of survey however resident refused. Resident will be offered shaving daily to remove facial hair to promote cleanliness and dignity. Staff have received re-education on the importance of grooming in nursing meetings on 6/7/18 and 6/8/18. All staff have received training on grooming tasks including shaving and will update the nurse with any refusals. Shaving preferences will be noted upon admission and staff will assist each resident with shaving as needed in the facility with their desired facial hair preference. Policy and procedure reviewed for shaving. 4 grooming audits will be completed weekly x 4 weeks by DON or designee and presented in quality council in July 31st 2018 and will review for need of ongoing audits. DON or designee will assess all resident□s need for and request a personal razor by 6/29/18. R26 Ambulation program order was not in matrix for the CNAs to sign off on. This	7/13/18

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F 677	Continued From page 9 chin areas. When asked whether staff helped her with shaving, R14 was unable to respond. R14's admission record indicated she'd been admitted to the facility on 4/23/14, and had diagnoses including: peripheral vascular disease, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right non-dominant side, dementia, anxiety disorder and hypertension. R14's annual Minimum Data Set (MDS) assessment dated 3/13/18, indicated she required extensive assist of one staff with personal hygiene needs, including shaving. Review of R14's care plan dated 3/14/18 revealed, "Resident is dependent on staff for cares et (and) mobility r/t (related to) history of a left cerebral hemorrhage in 2010 et cognitive deficits-(R) [right] hemiplegia, she is non-ambulatory". In addition, the care plan included, "extensive assist of 1-2 GROOMING/HYGIENE ..." The Nursing Assistant assignment sheet undated, included for R14, "ADL's - A1 (activities of daily living - assist of one)". During an interview with registered nurse (RN)-A on 5/22/18 at 10:39 a.m., RN-A verified R14's long facial hairs. At that time, RN-A asked R14 if she would like to be shaven and R14 nodded her head up and down, indicating she would. During an interview with nursing assistant (NA)-A on 5/22/18 at 10:43 a.m., NA-A verified R14's facial hairs were long and stated she would look for R14's shaver and if unable to find the razor,	F 677	was corrected on 5/23/18. The care card and care plan reflected ambulation program accurately. Staff have been re-educated in nursing meetings on 6/7/18 and 6/8/18 on importance of ambulation programs and the expectation that they are completed by the end of the shift, and the importance of documenting care completed. Discussed ambulation program with resident who agrees with plan. Staff will ambulate resident to meals and or around the neighborhood to ensure the ambulation program is completed daily per care plan unless she refuses. As of discussion with resident on 6/18/18 ambulation program was being completed per resident. Audits of all restorative and ambulation programs have been completed by the RN in charge of restorative programs and has ensured that they are correct in the order, care card, and care plan. To protect all other residents; audits of all restorative and ambulation programs have been completed by DON or designee. All plans are correct in the order, care card, and care plan. Policy and procedure was reviewed for restorative programs. Monitoring of all programs by review of POC charting will be conducted weekly X 3 weeks on all restorative programs; results will be reported to Quality Council. DON or designee will be monitoring all residents with restorative programs	

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F 677	Continued From page 10 would find one so R14 could be shaven. During an interview with the director of nursing (DON) on 5/22/18 at 11:17 a.m., the DON stated her expectation was staff needed to follow each resident's care plan and should shave residents who need it daily unless they refuse. The facility's policy Shaving the Resident dated October 2010, indicated, "The purpose of this procedure is to promote cleanliness and to provide skin care..." During interview on 5/21/18, at 9:35 a.m. R26 stated she was supposed to be walking daily but stated staff had not been assisting her walking since the move to the new facility approximately three weeks ago. The admission record indicated R26 had been admitted on 10/12/17 with diagnoses including depression, anxiety, chronic obstructive pulmonary disease, depression, chronic pain, muscle weakness and shortness of breath. A quarterly Minimum Data Set (MDS) assessment dated 4/5/18, indicated R26 was cognitively intact and utilized a wheelchair for mobility. R26's current daily ambulation program included: "Amb [ambulation] 10-50' [feet] with FWW [front wheeled walker], assist of 1 holding gait belt follow with w/c [wheelchair] and O2 [oxygen]." On 5/23/18, at 9:35 a.m. nursing assistant (NA)-C confirmed R26 had a walking program but stated they rarely had time to complete it. She stated, "we used to have restorative aids and now we don't. It's hard to get everything done and a lot of times these resident programs do not get completed."	F 677	monthly to ensure completion of programs.	

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F 677	Continued From page 11 On 5/22/18, at 9:52 a.m. R26 confirmed her walking program had not been offered the evening before or yet this morning. On 5/23/18 at 9:22 a.m. R26 stated her walking program had not been offered the day prior or yet that morning. Ambulation program records were reviewed and indicated R26's walking program had been implemented only 41 times in the last 120 days. During an interview with the director of nursing (DON) on 5/23/18, at 12:47 p.m. she stated the facility had a restorative aide in the previous facility, but that other workloads had been shifted around to accommodate that change. The DON added that mentors should be helping out and it would still be her expectation that PROM and walking programs were getting completed.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and	F 688		7/13/18

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F 688	Continued From page 12 assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the facility failed to provide restorative services necessary to maintain range of motion for 1 of 2 residents (R36) reviewed. Findings include: R36 was interviewed on 5/21/18, at 1:26 p.m. and stated, "I never get my range of motion. It has been months since that has been done in any kind of consistent manner." The admission record indicated R36's had been admitted to the facility on 1/16/18 with diagnoses of cancer and quadriplegia. A quarterly MDS dated 4/12/18, indicated R36 was cognitively intact, required total assistance with the majority of his daily living needs, and suffered from contractures in his right and left hand as a result of his condition, as well as right shoulder pain. R36's Physician's Order Report revealed a treatment order dated 1/16/18, for PROM (Passive Range of Motion) to be offered each shift with positioning, as an intervention for muscle spasms. During a follow up interview with R36 on 5/23/18 at 9:18 a.m., R36 stated his contractures felt as if they may have worsened and he continued to have a lot of discomfort and pain, but was not sure how much. His main concern was getting the PROM completed regularly.	F 688	F688 R36 PROM program, care plan, and care card reviewed and discussed with resident preference on time of day. Resident stated upon follow up by DON on 6/18/18 that program has been completed daily. Staff re-educated on importance of PROM program and an expectation that this program is completed by staff daily in the morning prior to resident getting up for the morning. A book of the PROM to be completed will be placed in resident□s room for staff review on 06/28/18 per resident preference. Nursing staff have been educated on ROM and understand expectation of program completion. To protect all residents audits of all restorative and ambulation programs have been completed by DON or designee and are correct in the order, care card, and care plan. Policy and procedure was reviewed for restorative programs. Monitoring of all programs by review of POC charting will be conducted weekly X 3 weeks and results will be reported to quality council for need for ongoing auditing. DON or designee will monitor all residents with restorative programs monthly to ensure completion of programs.	

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F 688	Continued From page 13 Although requested, no data regarding the PROM was provided from January until May 1, 2018. Data received for 5/1-5/16/18 indicated R36 was offered PROM 3 out of 32 opportunities. During an interview with the director of nursing (DON) on 5/23/18, at 12:47 p.m. she stated the facility had a restorative aide in the previous facility, but that other workloads had been shifted around to accommodate that change. The DON added that mentors should be helping out and it would still be her expectation that PROM and walking programs were getting completed.	F 688		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 812	Tag 483.60(i) Food safety	6/29/18

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 _____	05/23/2018

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 812	Continued From page 14 review, the facility failed to ensure processes were implemented to ensure food was stored and served in a safe manner, including ensuring hot foots were appropriately cooled prior to refrigeration, and ensuring dietary staff utilized appropriate sanitation procedures. This had the potential to affect 60 residents who received their meals from the kitchen. Findings include: During observations on 5/20/18 at 4:58 p.m., dietary assistant (DA)-B was observed wearing gloves while handling the paper order forms residents had handled to determine which meal they preferred. DA-B was observed to pick up the orders, and without hand washing or changing gloves, picked up sandwiches and put them on residents' plates. In addition, DA-B was observed to serve beverages by holding the glasses by the rim at the top of the glass. On 5/21/18 at 11:54 a.m., DA-C was observed wearing gloves on both hands. DA-C also handled the paper orders residents had handled, and without washing hands or changing gloves, handled slices of pizza for service to residents who had ordered pizza. On 5/22/18 at 8:22 a.m., DA-D was observed to wear glove, handle residents' paper order forms, and without washing hands, or changing gloves, picking up an English muffin for service, picking up a biscuit and tearing it prior to putting gravy on it for service. On 5/20/18 at 1:07 p.m., the kitchen was toured with the dietary supervisor and cook-A. Two pans of beef stroganoff were observed in pans in the	F 812	A. RE: Safe Food Storage It is the policy of St. Crispin Living Community to follow all Federal, State, and local guidelines, laws and regulations and statutes. This plan of correction is not to be construed as an admission of deficient practice by the facility administrator, employees, agents, or other individuals. The response to the alleged deficient practice cited in this statement of deficiencies does not constitute agreement with citation. The preparations, submission and implementation of this plan of correction will serve as our credible allegation of compliance. To address residents found to have been affected by the deficient practice; The Culinary Director reviewed and re-educated staff on the Cooling and Reheating of Potentially Hazardous Foods Policy and Log Form with all culinary staff who prepare food. To prevent recurrence with other residents having the potential to be affected by the same deficient practice; If reheated, food is brought to 165 degrees F for 15 seconds (according to the HACCP system) to prevent any food borne illness. All food temperatures are recorded on the cook's daily temperature log sheet and given to Culinary Supervisor or designee daily or as often as applicable.	

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	245449	A. BUILDING _____ B. WING _____	05/23/2018

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F 812	Continued From page 15 refrigerator. The dietary supervisor and cook-A stated the beef stroganoff had been made the previous night and had been brought out to be heated and thickened again this morning before being put back in the refrigerator. They stated the stroganoff was going to be served for dinner at 5:00 p.m. that evening. Cook-A stated there was a facility procedure for cooling hot food safely. At that time, cook-A measured the temperature of one pan of beef stroganoff which registered 130 degrees F (Fahrenheit), and the second pan measured at 140 F. The beef stroganoff was removed from the refrigerator at that time. On 5/21/18 at 9:58 a.m., the dietary director stated their hot food cooling procedure had not been followed for the stroganoff and staff would be re-educated immediately. The facility's policy Cooling and Heating of Potentially Hazardous foods procedure dated 5/10/17, included: "Potentially hazardous foods requiring refrigeration must be cooled by an adequate method so that every part of the product is reduced from 135 degrees Fahrenheit to 70 degrees Fahrenheit within 2 hours, and from 70 degrees Fahrenheit to 41 degrees Fahrenheit or below within four additional hours." "Cooling instructions: Alternatives of quick cooling techniques include, but are not limited to: stirring food in a container that is placed in an ice water bath; Cool food in a container that is 4 inches deep or less and place uncovered in the fridge on the top shelf in the back of the walk in fridge; Add ice as an ingredient" "Monitoring instructions: 1. Using a clean sanitized probe thermometer measure the internal temperature of the food during the cooling process. 2. Monitor temperatures of products every hour throughout	F 812	Systemic changes made to ensure that the deficient practice will not recur: Culinary employees will follow the Policy for Cooling and Reheating Potentially hazardous foods and Food Cooling Log form To monitor its performance to make sure that solutions are sustained. St. Crispin Living Community Culinary Supervisor will review Food Cooling Log each morning and initial to ensure proper procedure is being followed. If employee is found not following procedure, that employee will be re-educated on policy and corrective action will be taken. B. Distributing Safe Food (Glove Use) To address residents found to have been affected by the deficient practice; Culinary Director re-educated staff on the Glove Use and Hand Hygiene Policy per (DA)-B, C, D. To prevent recurrence with other residents having the potential to be affected by the same deficient practice; Culinary Director and Infection Preventionist will educate all Culinary Staff on Food Safety, Glove Use and Hand Hygiene. Staff will be tested with a quiz and must pass with 100% on all areas covered.	

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	245449	A. BUILDING _____ B. WING _____	05/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 16 the cooling process (until food temperature reaches 41 degrees Fahrenheit or less) by inserting the probe thermometer into the center of the food and at various locations in the product." The procedure included a cooling log with columns for: date, time, food item, method of cooling, temp at start & time, temp 2 hours after cooling, temp at 6 hours after cooling and initials.	F 812	Systemic changes made to ensure that the deficient practice will not recur: Culinary Director or designee will perform random Hand Hygiene Audits 2 times a week for 3 months starting 7-2-2018. To monitor its performance to make sure that solutions are sustained: If employee is found not to be following the Policy on Hand Hygiene and Glove Use, corrective action will be taken including re-educating that employee and corrective action. The Director of Culinary Services is responsible for compliance.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 14, 2018

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

RE: Project Number F5449083

Please Note: Life Safety Code (LSC) survey finding will follow in a separate notice.

Dear Mr. Goering:

On April 17, 2018, a standard survey was completed at your facility by the Minnesota Department of 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.

We are pleased to inform you that this survey resulted in no deficiencies being issued.

The Federal Form CMS-2567 is being electronically delivered.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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 _____	**04/17/2018**

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

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (St. Crispin Living Community) was found 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) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. The Facility is a 2 story building with an attached one story with basement (B) occupancy separted by a two hours wall. The facility was constructed in 2016 and was determined to be of Type II(111) construction. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 64 beds and had a census of 00 at the time of the survey.	K 000		

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

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.