Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 9, 2025

Administrator
State Operated Psychiatric Nursing Facili-St Peter
100 Freeman Drive
St Peter, MN 56082

Re: State Nursing Home Licensing Orders
Event ID: E8NQ11

Dear Administrator:

The above facility was surveyed on September 15, 2025 through September 16, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

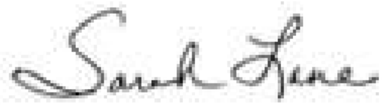
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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

Please feel free to call me with any questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25494	A. BUILDING: _____ B. WING _____	09/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATE OPERATED PSYCHIATRIC NURSING FA	100 FREEMAN DRIVE ST PETER, MN 56082

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/15/25 to 9/16/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE	2 000		

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview, and document review, the	2 302	Corrected	11-4-25

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2 302	Continued From page 3 facility failed to ensure consumers were provided information regarding Alzheimer's disease and dementia training, including a description of the training program, the categories of employees trained, the frequency of training and the basic topics covered in the training in a written or electronic form. This had the potential to affect all 30 residents and their families. Findings include: During a review of the facility's Alzheimer's training program, there was no information or documentation that indicated the consumers (resident and families) were provided a description of Alzheimer's training program, categories of employees trained, frequency of training and the basic topics covered. During interview on 9/16/25 at 3:47 p.m., director of nursing (DON) indicated consumer information related to Alzheimer's disease and dementia training was not posted or in their admission packets. At 4:25 p.m., DON stated she would contact the administrator to confirm if this was correct. At 4:37 p.m., DON confirmed the facility did not provide consumers the information related to Alzheimer's disease and dementia training. The facility policy titled Employee Learning And Development dated 7/1/25, identified Direct Care and Treatment (DCT) built and supported a learning organization that addressed the required training and development needs of staff. DCT offered learning opportunities for employees to increase their knowledge, skills and abilities through training programs and continuing education opportunities. The policy identified its purpose was to ensure DCT employees received the training and/or training resources to assist in	2 302		

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2 302	Continued From page 4 performing job duties, complying with applicable statutes, rules, regulations, standards, policies, and engaging in professional growth opportunities. The policy did not identify an Alzheimer's and dementia training program or how that training program information was provided to consumers. SUGGESTED METHOD OF CORRECTION: The DON or designee could add information regarding staff training to the resident admission packet or post it, so consumers were aware of this information. The DON or designee could educate staff about this requirement and conduct audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure food items in the facility kitchenette were properly labeled, dated, and not expired, which had the potential to affect all 30 residents in the facility. Findings Include: During an initial tour of the facility kitchenette on	21100	Corrected	11-4-25

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21100	Continued From page 5 9/15/25 at 1:10 p.m. with office administration specialist intermediate (OASI) the following was identified, and verified by OASI: -one clear package of approximately eight waffles was opened and undated in the freezer -one clear bag of four omelets was opened and undated -three clear bags of omelets were closed, but not dated -five clear pitchers of Kool-Aid were in the refrigerator, undated. Registered nurse (RN)-A entered the kitchenette and stated the Kool-Aid was usually drank in one day or more, depending on the weather and how much the residents drank. -one container of Redi-Whip topping was half full with an expiration date of 2/22/25 -sixteen individual packages of Lorna Doone cookies were in a drawer with expiration date of 2/12/25 -eighteen individual Lays regular potato chips were in a cardboard box on the counter with expiration date of 9/8/25 -various individual containers of other snacks, peanut butter and condiments removed from original containers were in drawers with no expiration dates on the packaging -six Tupperware containers of various dry cereals were undated During a phone interview on 9/15/25 at 4:38 p.m., dietary manager (DM) indicated the kitchen on campus delivered meals and snack foods to each facility on campus. DM stated foods in bags should be dated when opened. DM stated they provided stickers with dates on bags of items when delivered to the facilities. DM indicated she would check their process used for dried cereals when placed in containers at the facility. DM confirmed all expired food should be discarded at	21100		

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21100	Continued From page 6 the facility. During interview on 9/16/25 at 3:21 p.m., director of nursing (DON) stated she was responsible for staff who worked in the facility kitchenette, but operating procedures were overseen by the dietary department. DON indicated her expectation that all foods would be dated and have expiration dates on them. DON indicated the dietary department bought items in bulk and often sent them without original packaging. DON confirmed dry cereal in Tupperware containers were not dated. DON stated her expectation was that if foods were expired, they should be disposed of. DON confirmed the facility had not had any food borne illnesses. The facility policy titled Food Storage Guidelines And Leftovers dated 9/23, identified unit staff were to use the following guidelines which included: - label foods once opened with use by date, seven days from opened date -if there was any question about a product's storage or expiration, discard it -store food in the original packages or in containers that prevent damage to the food or original packaging <u>SUGGESTED METHOD OF CORRECTION</u>: The administrator, registered dietician, or designee could ensure foods were stored, labeled properly, and not expired to prevent potential degraded food served to residents of the facility. The facility could update or create policies and procedures and educate staff on specific requirements or interventions related to food storage, labeling, and expiration dates. The administrator, registered dietician, or designee could perform audits for a designated amount of	21100		

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21100	Continued From page 7 time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items are stored, labeled appropriately, and not expired. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21100		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and	21390	Corrected	11-7-25

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21390	Continued From page 8 I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate personal protective equipment (PPE) was worn to prevent the spread of infection for 1 of 1 residents (R1) observed for enhanced barrier precautions (EBP), (an infection control intervention designed to reduce transmission of multi-drug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). Findings Include: R 1's care plan revised 2/29/24, identified R1 had impaired thought process and had diagnosis which included schizoaffective disorder, bipolar, and benign prostatic hypertrophy (enlargement of the prostate gland). Identified R1 had a Foley catheter, and staff were to empty the urinary catheter as needed. Care plan lacked evidence of EBP. R1's order detail report dated 5/21/25, identified staff were required to change R1's urinary catheter every four weeks. During an interview on 9/15/25 at 1:10 p.m., R1 stated he has had a foley catheter for the past few months. R1 stated staff did not wear a gown while providing care to R1. During an observation on 9/15/25 at 1:26 p.m., nursing assistant (NA)-A sanitized hands and applied gloves, emptied R1's foley catheter into a graduate and emptied the graduate into the toilet.	21390		

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21390	Continued From page 9 NA-A removed the gloves, sanitized hands and left the room. At no time during the above observation was NA-A wearing a gown. During an observation on 9/15/25 at 1:36 p.m., NA-A and NA-B sanitized hands, applied gloves and entered R1's room. NA-A and NA-B proceeded to place a sling behind R1 and attached the sling to the standing lift. NA-A and NA-B instructed R1 to stand up tall as NA-A placed her hand on R1's back. NA-A and NA-B stood next to R1 for five minutes while R1 stood in the standing lift. NA-A and NA-B then placed R1 back into his wheelchair, and removed the sling from R1. NA-A and NA-B removed their gloves and sanitized hands. At no time during the above observation was NA-A or NA-B wearing a gown. During a joint interview on 9/15/25 at 1:45 p.m., NA-A and NA-B indicated R1 had a foley catheter. NA-A and NA-B stated they were only required to wear gloves while providing care to R1. NA-A and NA-B stated they were not aware of any time a gown was required while caring for R1. During an observation on 9/15/25 at 6:10 p.m., NA-C wheeled R1 to his room while NA-D wheeled the standing lift into R1's room. NA-C and NA-D applied gloves and placed a sling behind R1 and attached the sling to the standing lift. NA-C and NA-D wheeled R1 in the lift to the toilet and NA-C pulled down R1's pants and placed R1 on the toilet. NA-C told R1 to pull the call light when he was done. NA-C removed her gloves, sanitized her hands and exited the room. During a joint interview on 9/15/25 at 6:18 p.m., NA-C and NA-D indicated R1 had a foley catheter. NA-C and NA-D stated the only PPE	21390		

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21390	Continued From page 10 required to care for R1 was gloves. NA-C and NA-D stated they were not aware of EBP. During an interview on 9/16/25 at 8:44 a.m., registered nurse (RN)-B verified R1 had a foley catheter for the past three months. RN-B stated staff were only to wear gloves while providing high-contact care to any residents. RN-B stated she had not heard of EBP. RN-B stated her expectation was that the facility would have implemented EBP. During an interview on 9/16/25 at 11:50 a.m., infection preventionist (IP) verified R1 has had a foley catheter since 5/21/25. IP stated she had heard of EBP a while back during a webinar provided by Minnesota Department of Health (MDH). IP stated she thought that EBP was only a recommendation from MDH and was not aware of the EBP guidance from the CDC. IP stated now that she is aware of the CDC guidance her expectation is that the facility would implement EBP per CDC guidelines to prevent the spread of infection. During an interview on 916/25 at 2:33 p.m., director of nursing (DON) stated her expectation was that EBP would have been implemented per CDC guidelines to prevent the spread of infection. A policy on EBP was requested, one was not provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review policies and procedures to ensure, proper infection control regarding EBP practices were followed. Facility staff could be reeducated and an auditing system developed to ensure compliance.	21390		

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21390	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21390		