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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: O7UB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00815

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245484**

2.STATE VENDOR OR MEDICAID NO.
(L2) **177240600**

3. NAME AND ADDRESS OF FACILITY
(L3) **VILLA ST VINCENT**
(L4) **516 WALSH STREET**
(L5) **CROOKSTON, MN** (L6) **56716**

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)

6. DATE OF SURVEY **02/03/2015** (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)
12/31

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

12.Total Facility Beds **104** (L18)

13.Total Certified Beds **104** (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
___ 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: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	104			
(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 :
Debra Vincent, HFE NEII — 02/04/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 03/10/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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
06/01/1987
(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
01/20/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245484

February 5, 2015

Ms. Judith Hulst, Administrator
Villa St Vincent
516 Walsh Street
Crookston, Minnesota 56716

Dear Ms. Hulst:

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 December 22, 2014 the above facility is certified for:

104 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 104 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
February 4, 2015

Ms. Judith Hulst, Administrator
Villa St Vincent
516 Walsh Street
Crookston, Minnesota 56716

RE: Project Number S5484024

Dear Ms. Hulst:

On December 16, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 4, 2014. 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 February 3, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 4, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 26, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 4, 2014, effective December 22, 2014 and therefore remedies outlined in our letter to you dated December 16, 2014, 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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-96 5484r15

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245484	A. Building B. Wing	2/3/2015

Name of Facility	Street Address, City, State, Zip Code
VILLA ST VINCENT	516 WALSH STREET CROOKSTON, MN 56716

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **12/22/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/22/2014**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **12/22/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **12/22/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **12/22/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	02/04/2015	32981	02/03/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/4/2014			

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
February 4, 2015

Ms. Judith Hulst, Administrator
Villa St Vincent
516 Walsh Street
Crookston, Minnesota 56716

Re: Reinspection Results - Project Number S5484024

Dear Ms. Hulst:

On February 3, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 4, 2014. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00815	A. Building B. Wing	2/3/2015

Name of Facility	Street Address, City, State, Zip Code
VILLA ST VINCENT	516 WALSH STREET CROOKSTON, MN 56716

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	Correction Completed **12/22/2014**	ID Prefix **20915** Reg. # **MN Rule 4658.0525 Subp. 6 A** LSC	Correction Completed **12/22/2014**	ID Prefix **21200** Reg. # **MN Rule 4658.0680 Subp. 6 A-I** LSC	Correction Completed **12/22/2014**
ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Subd. 3** LSC	Correction Completed **12/22/2014**	ID Prefix **21600** Reg. # **MN Rule 4658.1335 Subp. 2** LSC	Correction Completed **12/22/2014**	ID Prefix **21805** Reg. # **MN St. Statute 144.651 Subd. 5** LSC	Correction Completed **12/22/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	02/04/2015	32981	02/03/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/4/2014			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245484	VILLA ST VINCENT

Type of Survey (select all that apply):

D					

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

D					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 32981	02-02-2015	02-03-2015	1.00	0.00	10.50	0.00	3.50	1.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.00

Total Clerical/Data Entry Hours..... 3.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... N

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: O7UB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00815

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245484**
2.STATE VENDOR OR MEDICAID NO.
(L2) **177240600**

3. NAME AND ADDRESS OF FACILITY
(L3) **VILLA ST VINCENT**
(L4) **516 WALSH STREET**
(L5) **CROOKSTON, MN** (L6) **56716**

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)

6. DATE OF SURVEY **12/04/2014** (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)
12/31

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

12.Total Facility Beds **104** (L18)

13.Total Certified Beds **104** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	104			
(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 :
Debra Vincent, HFE NE II 12/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 01/19/2015 (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
06/01/1987
(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
Posted 01/20/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
December 16, 2014

Ms. Judith Hulst, Administrator
Villa St Vincent
516 Walsh Street
Crookston, Minnesota 56716

RE: Project Number S5484024

Dear Ms. Hulst:

On December 4, 2014, a standard 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 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. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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 a "F" tag), i.e., the plan of correction should be directed to:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

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 December 13, 2014, 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 December 13, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (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 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, 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 March 4, 2015 (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 June 4, 2015 (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
Division of Compliance Monitoring
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.

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:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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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 _____	12/04/2014

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
F 000	INITIAL COMMENTS 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 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a dignified, homelike dining experience for 24 of 24 residents (R127, R112, R103, R89, R106, R77, R66, R30, R79, R71, R108, R64, R101, R102, R80, R29, R62, R59, R60, R83, R6, R91, R97, R113) residing in the special care unit (dementia unit) who received their meals on trays. Findings include: On 12/1/14, at 5:45 p.m. all 24 residents (R127, R112, R103, R89, R106, R77, R66, R30, R79,	F 241	R127, R112, R103, R89, R106, R77, R71, R108, R64, R101, R80, R6, R91, & R113 are being provided with dignified, homelike dining experience while residing in the special care unit (dementia care). Meals are no longer consumed on the trays. For all other residents who may be affected by this practice an audit was completed in the dining room to be sure all residents' meals are not consumed on a tray. Education has been given to	12/26/14

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

Electronically Signed | 12/22/2014

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F 241	Continued From page 1 R71, R108, R64, R101, R102, R80, R29, R62, R59, R60, R83, R6, R91, R97, R113) were observed in the special care unit dining room. The evening meal arrived in a dietary cart. Staff was observed to deliver a meal tray to each resident that included an insulated plate with a domed cover, as well as cold items and beverages. As each tray was delivered to the resident, the domed cover was removed from the plate and stacked on the table. Each resident was observed to eat their meal from the tray. Subsequent meal observations on the special care unit occurred on 12/2/14, at 8:34 a.m. on 12/3/14, at 8:34 a.m. on 12/3/14, at 12:00 p.m. and on 12/4/14, at 8:35 a.m. During each meal, all residents were observed to be served and eat their meals from the trays. On 12/4/14, at 9:02 a.m. nursing assistant (NA)-B stated the special care unit did not have dietary staff serving meals like they did on the other units. She stated the meals came on the trays so it was just easier to serve the residents their meals on the tray. On 12/04/2014, at 10:33 a.m. NA-C stated the other dining rooms had servers so those meals were dished up and served on a plate, but in the unit, the meals came on trays so they had always served the meals on a tray. NA-C stated that was how she was trained and had never done it any differently. On 12/04/2014, at 10:48 a.m. NA-D stated they had always served the meals on the special care unit this way and did not know of any special reason as to why it was done that way.	F 241	nursing staff that routinely work in the special care unit during meal time. Audits will be completed through the next 6 months and then as needed according to the quality council schedule regarding meals not being consumed on a tray. A policy for meals not being consumed on a tray in the special care unit was revised by the interdisciplinary team. Audit results will be reported to the QA Committee for review and further recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated. The Director of Nursing and Dietary Manager will be responsible for compliance.	

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F 241	Continued From page 2 On 12/04/2014, at 1:33 p.m. licensed practical nurse (LPN)-B stated the other dining rooms had servers but the unit was sent their meals on a cart. She indicated they had done it that way for as long as she had worked there. LPN-B stated they needed to load the dishes and trays back into the dietary cart when the residents were done eating so they left the dishes on the trays. On 12/04/2014, at 2:24 p.m. the dietary manager (DM) confirmed they served meals on trays in the special care unit and stated there was no reason to do so. The DM agreed it could be perceived as a dignity issue. A dining policy was requested but none was provided.	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R143) received ambulation services in accordance with the care plan. In addition, the facility failed to ensure anti-roll lock brakes were implemented for 1 of 3 residents (R34) as directed by the care plan. Findings include:	F 282	R143 facility has ensured that resident is receiving ambulation services in accordance with the care plan. Resident's ambulation program has been set up and he is on an ambulation program. R34 facility has ensured that resident has been equipped with anti-roll lock brakes as directed by care plan. For all others that may have been affected	12/26/14

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F 282	Continued From page 3 R143 did not receive ambulation services as directed by the care plan. R143's care plan dated 11/16/14, indicated R143 was on a functional maintenance ambulation program and directed one staff to assist R143 to ambulate 350 feet with a walker 1-2 times per day during the day and evening shifts. On 12/3/14, at 9:00 a.m. R143 was observed in the dining room seated in a wheelchair. Upon completion of the breakfast meal, R143 was observed to independently wheel himself away from the dining table and stopped to talk with surveyor. R143 stated he used his wheelchair to get to the dining room and used his walker in between. He stated he did not think he was on a walking program. At 11:50 a.m. nursing assistant (NA)-A stated R143 was not on a walking program but she had ambulated him to the bathroom that morning. At 11:55 a.m. RN-A verified R143's care plan was correct and stated the ambulation program was not set up and should have been. The facility's Ambulate - Cane / Walker policy and procedure dated 12/02, indicated nursing staff would encourage and assist the resident to walk with the cane / walker as per care plan or physician's orders.	F 282	by this practice an audit was done. All ambulation programs have been set up and implemented per plan of care. All anti-roll lock brakes are on as directed by the care plan. Education has been given to nursing staff that routinely work with ambulation and anti-roll lock brakes. Audits will be completed through the next 6 months and then as needed according to the quality council schedule regarding ambulation and anti-roll brakes. The policy for ambulation process and auto brake and anti-tip policy has been reviewed and revised by the anti-disciplinary team. Audit results will be reported to the QA Committee for review and further recommendations. Upon this review, stystem revisions and/or staff education will be implemented if indicated. Resotrative Nurse and Unit Managers will be responsible for compliance.	

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F 282	Continued From page 4 R34's wheelchair was not equipped with anti-roll back brakes as directed by the care plan. R34's care plan dated 11/6/14, indicated, R34 was at risk for falls related to weakness, recent dizziness and falls. R34's care plan further indicated falls on 6/6/14, 6/21/14, 6/24/14 and 6/30/14. Interventions following fall on 6/30/2014, indicated anti-roll back brakes were to be placed on R34's wheelchair. On 12/4/14, R34 was observed in her room, seated in the wheelchair. No anti-roll back brakes were observed on the wheelchair. On 12/4/14, at 9:59 a.m. RN-B observed R34's wheelchair and confirmed the chair did not have the anti-roll brakes in place and stated they should be especially because of her fall history. On 12/4/14, at 10:03 a.m. RN-C verified R34 was to have anti-roll back brakes placed on her wheelchair as directed by the care plan and confirmed they were not. On 12/4/14, at 10:40 a.m. the director of nursing (DON) stated, "it would be an expectation that the care plan be followed and the interventions done." The undated Auto brake and anti-tip bars policy and procedure indicated: auto brakes and anti tip-bars will be placed on wheelchairs when it is determined through nurse assessment there is a need for the auto brakes and/ or anti-tip bars. To enhance safety and prevent falls.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS	F 311		12/26/14

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F 311	Continued From page 5 A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R143) received ambulation services in accordance with their assessed needs. Findings include: R143's admission Minimum Data Set (MDS) dated 10/15/14, revealed his cognition was moderately impaired and was diagnosed with a cardio vascular attack (stroke) and depression. The MDS also identified R143 sustained falls and required extensive assist with transfers, locomotion and ambulation. R143's care plan revised 11/16/14, indicated R143 was on a functional maintenance ambulation program and directed one staff to assist R143 to ambulate 350 feet with a walker 1-2 times per day during the day and evening shifts. R134's Functional Maintenance / Restorative Program form dated 11/16/14, indicated an ambulation plan which consisted of one staff assist to ambulate 350 feet 1-2 times per day. The form also indicated R134 was to be provided verbal cues to not shuffle feet while walking and	F 311	R143 facility has ensured that resident is receiving ambulation services in accordance with his assessed needs. Functional Maintenance ambulation program dated 11/16/2014 has been set up and implanted. he is on an ambulation program. For all others taht may have been affected by this practice and audit was done. All ambulation programs have been set up and implemented per plan of care. Education has been given to nursing staff that routinely work with ambulation. Audits will be completed through the next 6 months and then as needed according to the quality councilschedule regarding ambulation plan. The policy for ambulation process has been reviewed and revised by the anti-disciplinary team. Audit results will be reported to the QA Committee for review and further recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated. Resotrative Nurse and Wellness Director will be responsible for compliance.	

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F 311	Continued From page 6 directional cues. On 12/3/14, at 9:00 a.m. R143 was observed in the dining room seated in a wheelchair. Upon completion of the meal, R143 was observed to wheel himself away from the dining table and stopped to talk with surveyor. R143 stated he used his wheel chair to go to the dining room and used his walker in between. He stated he did not think he was on a walking program. At 11:50 a.m. nursing assistant (NA)-A stated R143 was not on a walking program but she had walked him to the bathroom that morning. At 11:55 a.m. registered nurse (RN)-A verified R143 was not on an ambulation program and stated R143 should have been set up for the program as directed by the functional maintenance restorative directions and stated he had not set the ambulation program up for staff to implement. At 1:45 p.m. RN-A stated R143's ambulation program was now set up for R143 to be ambulated 350 feet on the day and evening shifts with one staff assist, a front wheeled walker and directions to provide verbal cues to not shuffle feet when walking. The facility's Ambulate - Cane / Walker policy and procedure dated 12/02, indicated ambulation of the resident would improve circulation and increase or maintain muscle strength and	F 311		

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F 311	Continued From page 7 independent activity and directed nursing staff to encourage and assist the resident to walk with the cane / walker as per care plan or physician's orders.	F 311		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure anti-roll brakes were implemented on the wheelchair for 1 of 3 residents (R34) reviewed for accidents. In addition the facility failed to ensure safe use of oxygen for 1 of 1 resident (R77) in the beauty shop who was observed under the hairdryer with oxygen on. Findings include: R34 did not have anti-roll back brakes implemented on her wheelchair as indicated on the care plan. R34's care plan dated 11/6/14, indicated R34 was at risk for falls related to weakness, recent	F 323	R34 facility has ensured that resident has been equipped with anti-roll lock brakes on w/c as indicated on the care plan and R77 was immediately removed from the beauty shop and hair dryer while on oxygen after being alerted. For all others that may have been affected by this practice and audit was done. All anti-roll lock brakes are on as directed by the care plan. All residents on oxygen will not be placed under the hair dryer. Eduaction has been given to nursing staff in regards to anti-roll lock brakes and beauty shop attendants in regards to oxygen and hair dryer use. Audits will be completed through the next 6 months and then as needed according to the quality council schedule regarding anti-roll lock brakes and oxygen use in the beauty shop	12/26/14

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F 323	Continued From page 8 dizziness and falls. The care plan further indicated R34 had falls on 6/6/14, 6/21/14, 6/24/14, and 6/30/14. Interventions following the fall on 6/30/2014, indicated wheelchair anti-roll back brakes would be ordered and implemented. R34's Annual Fall Risk Assessment dated 11/7/14, indicated a risk for falls with diagnoses of Parkinson's, restless leg syndrome and osteoporosis which put R34 at risk for falls and injury. The assessment further indicate R34 was on a fall prevention plan. On 12/4/14, R34 was observed in her room seated in a wheelchair. Anti-lock brakes were not observed on the wheelchair. On 12/4/14, at 9:59 a.m. RN-B observed R34's wheelchair and verified the anti-roll back brakes were not on as directed and stated with R34's history of falls, they should be. On 12/4/14, at 10:03 a.m. RN-C stated she knew she had placed an order for the anti-roll brakes and they should been placed on R34's wheelchair because she had updated R34's care plan to include the addition of the anti-roll brakes. RN-C verified R34's care plan was correct and was not followed as directed. On 12/4/14, at 10:40 a.m. the director of nursing (DON) stated, "it would be an expectation that the care plan be followed and the interventions done." The undated Auto brake and anti-tip bars policy and procedure indicated auto brakes and anti-tip bars would be placed on wheelchairs when it was determined through nurse assessment there was	F 323	while under hair dryer. The policy for anti-roll lock brakes and oxygen use under the hair dryer in the beauty shop has been reviewed and revised by the anti-disciplinary team. Audit results will be reported to the QA Committee for review and further recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated. Unit Managers and Enrichment Coordinator will be responsible for compliance.	

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F 323	Continued From page 9 a need for the them to enhance resident safety and prevent falls. R34 was observed under the beauty shop hairdryer with oxygen on. R77's admission Minimum Data Set (MDS) dated 8/27/14, identified R77 had severe cognitive impairment and required oxygen therapy. The MDS also identified R77 had diagnoses that included dementia, anxiety and chronic obstructive pulmonary disease. R77's Physician Order Report dated 12/4/14, included orders for oxygen at 2 liters per minute via nasal cannula, continuously. On 12/04/14, at 9:12 a.m. R77 was observed in the beauty shop seated in a wheelchair under a bonnet hair dryer. R77 had oxygen on via nasal cannula attached to a portable oxygen tank. The oxygen tank had been removed from the sleeve on the back of R77's chair and was sitting in an oxygen transport cart two feet from R77's wheelchair. On 12/04/14, at 9:16 a.m. the survey staff notified registered nurse (RN)-G who confirmed R77 should not have oxygen on while under the hair dry and immediately went to the beauty shop and removed R77 from the hair dryer. On 12/04/2014, at 9:17 a.m. activity assistant (AA) stated she usually took residents' oxygen off when under the hair dryer but there were certain residents, like R77, who did not tolerate it. AA stated R77 would hold her breath when her	F 323		

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F 323	Continued From page 10 oxygen was removed and AA wasn't sure what to do. On 12/04/2014, at 3:04 p.m. RN-G confirmed it was an issue for R77 to be under the hair dryer with oxygen on. RN-G stated AA should have contacted her if she had a question about how to proceed. On 12/04/14 at 3:10 p.m. director of nursing (DON) confirmed R77 should not have had oxygen on while under the hair dryer. The OXYGEN USE - SAFETY PRECAUTIONS policy dated 12/2002, stated all licensed nursing staff are oriented on the safe use of oxygen prior to administration and are expected to follow appropriate safety precautions. The policy did not address the use of hair dryers.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure pots and pans were sanitized properly in order to minimize the	F 371	Culinary Services staff that utilize the three compartment sink for manual washing of pots and pans will document	12/26/14

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F 371	Continued From page 11 risk of food borne illness. This had the potential to affect all 101 residents who resided in the facility and received meals from the facility kitchen. Findings include: On 12/1/14, at 2:00 p.m. during the initial tour with the dietary technician (DT), several pots and pans were observed standing upright next to the three compartment sink. There was a bright yellow sign posted above the sink that read, caution 180 degrees Fahrenheit (F) water. The DT stated if the dishwasher was full and busy the pots and pans would be washed and sanitized in the three compartment sink. The DT stated the sink did not contain a chemical sanitizer therefore the final rinse water in the third sink compartment was to be 180 degrees to ensure sanitization of the pots and pans. The DT stated the facility did not have documentation or a temperature log / record of the final rinse water to ensure the sanitization rinse water met the 180 degree heat requirement. -Cook (C)-A stated she had not checked the final rinse water temperature with a thermometer. The DT confirmed the final rinse water in the third sanitizing sink compartment was not checked and stated they relied on the water booster heater for adequate sanitizing water temperatures. On 12/4/14, at 8:58 a.m. dietary Aide (DA)-A stated the pots and pans that were drying by the three compartment sink were washed in the three compartment sink, air dried and put back in the food preparation area for use. At this time, C-B was observed to put pots and pans observed air drying next to the three compartment sink back	F 371	the temperature of the water in the third sink used for sanitizing the pots and pans to be assured that it reaches the desired temperature. The water in the sink must reach a minimum of 180 degrees. The temperature log will be located near the area of the three compartment sink. Staff have recieved instruction. Designated Person in Charge: Culinary Servies Managers will audit	

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 _____	12/04/2014

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

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F 371	Continued From page 12 into the food preparation area for use. DA-B stated the pots and pans that C-B put away were not sent through the dishwasher. The facility's undated Hand Washing of Pots and Pans procedure bullet #3, indicated a three compartment sink was to be utilized as follows for a complete washing cycle by hand of pots and pans. The procedure directed staff to wash the pots and pans in the first compartment, rinsed in hot water in the second compartment and sanitizing was accomplished in the third compartment by complete immersion for 30 seconds in 170 F water then air dried. The procedure also indicated it was highly recommended that all pots/pans be run through the dishwashing machine for sanitization.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245484	A. BUILDING **02 - 1975 EAST BUILDING** B. WING _____	**12/04/2014**

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

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Villa St Vincent was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 at least a 2-hour fire barrier. In 1993 a 1-story addition was constructed to the north east of the original 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 installed in accordance with NFPA 13 Installation of Sprinkler Systems 1999 edition. The 1993 and 2003 additions use quick response sprinkler heads. The facility has a fire alarm system with corridor smoke detection and	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.

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	245484	A. BUILDING **02 - 1975 EAST BUILDING** B. WING _____	**12/04/2014**

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K 000	Continued From page 1 smoke detectors in all common areas, installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Addition detectors are in all sleeping rooms of the 1993, 2003 additions and all hazardous areas have automatic detection in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 104 beds and had a census of 101 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

Electronically submitted
December 16, 2014

Ms. Judith Hulst, Administrator
Villa St Vincent
516 Walsh Street
Crookston, Minnesota 56716

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5484024

Dear Ms. Hulst:

The above facility was surveyed on December 1, 2014 through December 4, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule 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 Lyla Burkman at (218) 308-2104 or email: lyla.burkman@state.mn.us

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 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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

cc Licensing and Certification File

5484s15lic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00815	A. BUILDING: _____ B. WING _____	12/04/2014

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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: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 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. On 12/1/14, 12/2/14, 12/3/14, and 12/4/14, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R143) received ambulation services in accordance with the care plan. In addition, the facility failed to ensure anti-roll lock brakes were implemented for 1 of 3 residents (R34) as directed by the care plan. Findings include: R143 did not receive ambulation services as directed by the care plan. R143's care plan dated 11/16/14, indicated R143 was on a functional maintenance ambulation program and directed one staff to assist R143 to ambulate 350 feet with a walker 1-2 times per day during the day and evening shifts.	2 565	No plan of correction is needed for this. R143 facility has ensured that resident is receiving ambulation services in accordance with the care plan. Resident's ambulation program has been set up and he is on an ambulation program. R34 facility has ensured that resdient has been equipped with anti-roll lock brakes as directed by care plan. For all others that may have been affected by this practice an audit was done. All ambulation programs have been set up and implemented per plan of care. All anti-roll lock brakes are on as directed by the care plan. Education has been given to nursing staff that routinely work with ambulation and anti-roll lock brakes. Audits will be completed through the next 6 months and then as needed according	12/26/14

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2 565	Continued From page 3 On 12/3/14, at 9:00 a.m. R143 was observed in the dining room seated in a wheelchair. Upon completion of the breakfast meal, R143 was observed to independently wheel himself away from the dining table and stopped to talk with surveyor. R143 stated he used his wheelchair to get to the dining room and used his walker in between. He stated he did not think he was on a walking program. At 11:50 a.m. nursing assistant (NA)-A stated R143 was not on a walking program but she had ambulated him to the bathroom that morning. At 11:55 a.m. RN-A verified R143's care plan was correct and stated the ambulation program was not set up and should have been. The facility's Ambulate - Cane / Walker policy and procedure dated 12/02, indicated nursing staff would encourage and assist the resident to walk with the cane / walker as per care plan or physician's orders. R34's wheelchair was not equipped with anti-roll back brakes as directed by the care plan. R34's care plan dated 11/6/14, indicated, R34 was at risk for falls related to weakness, recent dizziness and falls. R34's care plan further indicated falls on 6/6/14, 6/21/14, 6/24/14 and 6/30/14. Interventions following fall on 6/30/2014,	2 565	to the quality council schedule regarding ambulation and anti-roll brakes. The policy for ambulation process and auto brake and anti-tip policy has been reviewed and revised by the anti-disciplinary team. Audit results will be reported to the QA Committee for review and further recommendations. Upon this review, stystem revisions and/or staff education will be implemented if indicated. Resotrative Nurse and Unit Managers will be responsible for compliance.	

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2 565	Continued From page 4 indicated anti-roll back brakes were to be placed on R34's wheelchair. On 12/4/14, R34 was observed in her room, seated in the wheelchair. No anti-roll back brakes were observed on the wheelchair. On 12/4/14, at 9:59 a.m. RN-B observed R34's wheelchair and confirmed the chair did not have the anti-roll brakes in place and stated they should be especially because of her fall history. On 12/4/14, at 10:03 a.m. RN-C verified R34 was to have anti-roll back brakes placed on her wheelchair as directed by the care plan and confirmed they were not. On 12/4/14, at 10:40 a.m. the director of nursing (DON) stated, "it would be an expectation that the care plan be followed and the interventions done." The undated Auto brake and anti-tip bars policy and procedure indicated: auto brakes and anti tip-bars will be placed on wheelchairs when it is determined through nurse assessment there is a need for the auto brakes and/ or anti-tip bars. To enhance safety and prevent falls. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could schedule an in service to disuss the importance of following the	2 565		

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2 565	Continued From page 5 resident care plans related to ambulation and safety interventions. The director of nursing or designee could perform random observational / record review audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 565		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R143) received ambulation services in accordance with their assessed needs. Findings include:	2 915	No plan of correction is needed. R143 facility has ensured that resident is receiving ambulation services in accordance with the care plan. Resident's ambulation program has been set up and	12/26/14

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2 915	Continued From page 6 R143's admission Minimum Data Set (MDS) dated 10/15/14, revealed his cognition was moderately impaired and was diagnosed with a cardio vascular attack (stroke) and depression. The MDS also identified R143 sustained falls and required extensive assist with transfers, locomotion and ambulation. R143's care plan revised 11/16/14, indicated R143 was on a functional maintenance ambulation program and directed one staff to assist R143 to ambulate 350 feet with a walker 1-2 times per day during the day and evening shifts. R134's Functional Maintenance / Restorative Program form dated 11/16/14, indicated an ambulation plan which consisted of one staff assist to ambulate 350 feet 1-2 times per day. The form also indicated R134 was to be provided verbal cues to not shuffle feet while walking and directional cues. On 12/3/14, at 9:00 a.m. R143 was observed in the dining room seated in a wheelchair. Upon completion of the meal, R143 was observed to wheel himself away from the dining table and stopped to talk with surveyor. R143 stated he used his wheel chair to go to the dining room and used his walker in between. He stated he did not think he was on a walking program. At 11:50 a.m. nursing assistant (NA)-A stated	2 915	he is on an ambulation program. For all others that may have been affected by this practice an audit was done. All ambulation programs have been set up and implemented per plan of care. Education has been given to nursing staff that routinely work with ambulation and anti-roll lock brakes. Audits will be completed through the next 6 months and then as needed according to the quality council schedule regarding ambulation. The policy for ambulation process has been reviewed Audit results will be reported to the QA Committee for review and further recommendations. Upon this review, stystem revisions and/or staff education will be implemented if indicated. Resotrative Nurse and Unit Managers will be responsible for compliance.	

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2 915	Continued From page 7 R143 was not on a walking program but she had walked him to the bathroom that morning. At 11:55 a.m. registered nurse (RN)-A verified R143 was not on an ambulation program and stated R143 should have been set up for the program as directed by the functional maintenance restorative directions and stated he had not set the ambulation program up for staff to implement. At 1:45 p.m. RN-A stated R143's ambulation program was now set up for R143 to be ambulated 350 feet on the day and evening shifts with one staff assist, a front wheeled walker and directions to provide verbal cues to not shuffle feet when walking. The facility's Ambulate - Cane / Walker policy and procedure dated 12/02, indicated ambulation of the resident would improve circulation and increase or maintain muscle strength and independent activity and directed nursing staff to encourage and assist the resident to walk with the cane / walker as per care plan or physician's orders. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review and revise policies and provide staff training to ensure ambulation services are provided according to the residents care plan. A designated staff member could monitor the ambulation program to assure ambulation services are provided according to the plan of care.	2 915		

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2 915	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 915		
21200	MN Rule 4658.0680 Subp. 6 A-E Manual Cleaning and Sanitizing; Methods Subp. 6. Sanitization methods. The food-contact surfaces of all equipment and utensils must be sanitized by one of the following methods: A. immersion for at least one-half minute in clean, hot water at a temperature of at least 170 degrees Fahrenheit (77 degrees centigrade); B. immersion for at least one minute in a clean solution containing at least 50 parts per million, but no more than 200 parts per million, of available chlorine as a hypochlorite and at a temperature of at least 75 degrees Fahrenheit (24 degrees centigrade); C. immersion for at least one minute in a clean solution containing at least 12.5 parts per million, but not more than 25 parts per million, of available iodine and having a pH range which the manufacturer has demonstrated to be effective and at a temperature of at least 75 degrees Fahrenheit (24 degrees centigrade); D. immersion in a clean solution containing any other chemical sanitizing agent allowed under Code of Federal Regulations, title 21, section 178.1010, that will provide at least the equivalent bactericidal effect of a solution containing 50 parts per million of available chlorine as a hypochlorite at a temperature of at least 75 degrees Fahrenheit (24 degrees centigrade) for one minute; or E. for equipment too large to sanitize by immersion, but in which steam can be confined, treatment with steam free from materials or additives other than those specified in Code	21200		12/26/14

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21200	Continued From page 9 of Federal Regulations, title 21, section 173.310. Equipment too large to sanitize by immersion must be rinsed, sprayed, or swabbed with a sanitizing solution of at least twice the required strength for that particular sanitizing solution. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure pots and pans were sanitized properly in order to minimize the risk of food borne illness. This had the potential to affect all 101 residents who resided in the facility and received meals from the facility kitchen. Findings include: On 12/1/14, at 2:00 p.m. during the initial tour with the dietary technician (DT), several pots and pans were observed standing upright next to the three compartment sink. There was a bright yellow sign posted above the sink that read, caution 180 degrees Fahrenheit (F) water. The DT stated if the dishwasher was full and busy the pots and pans would be washed and sanitized in the three compartment sink. The DT stated the sink did not contain a chemical sanitizer therefore the final rinse water in the third sink compartment was to be 180 degrees to ensure sanitization of the pots and pans. The DT stated the facility did not have documentation or a temperature log / record of the final rinse water to ensure the sanitization rinse water met the 180 degree heat requirement.	21200	No plan of correction is needed for this. Culinary Services staff that utilize the three compartment sink for manual washing of pots and pans will document the temperature of the water in the third sink used for sanitizing the pots and pans to be assured that it reaches the desired temperature. The water in the sink must reach a minimum of 180 degrees. The temperature log will be located near the area of the three compartment sink. Staff have recieved instruction. Designated Person in Charge: Culinary Servies Managers will audit.	

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21200	Continued From page 10 -Cook (C)-A stated she had not checked the final rinse water temperature with a thermometer. The DT confirmed the final rinse water in the third sanitizing sink compartment was not checked and stated they relied on the water booster heater for adequate sanitizing water temperatures. On 12/4/14, at 8:58 a.m. dietary Aide (DA)-A stated the pots and pans that were drying by the three compartment sink were washed in the three compartment sink, air dried and put back in the food preparation area for use. At this time, C-B was observed to put pots and pans observed air drying next to the three compartment sink back into the food preparation area for use. DA-B stated the pots and pans that C-B put away were not sent through the dishwasher. The facility's undated Hand Washing of Pots and Pans procedure bullet #3, indicated a three compartment sink was to be utilized as follows for a complete washing cycle by hand of pots and pans. The procedure directed staff to wash the pots and pans in the first compartment, rinsed in hot water in the second compartment and sanitizing was accomplished in the third compartment by complete immersion for 30 seconds in 170 F water then air dried. The procedure also indicated it was highly recommended that all pots/pans be run through the dishwashing machine for sanitization. SUGGESTED METHOD OF CORRECTION: The food service director (FSD) could review and revise policies and procedures for proper use of the three compartment sink for sanitization purposes. In addition, the (FSD) or designated staff member could provide training for all	21200		

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21200	Continued From page 11 involved staff and perform observational audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21200		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 newly admitted residents (R111) received timely tuberculosis (TB) symptom screening.	21426	The Director of Nursing has reviewed the policy and provided education to the Nursing Management team. Audit will periodically done by Quality Assurance.	12/26/14

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21426	Continued From page 12 Findings include: R111 was admitted to the facility on 7/22/14, with diagnoses Parkinson and depression. R111's progress note dated 7/29/14, (7 days after admission) indicated the nursing staff had completed a TB symptom screening. On 12/04/14, at 10:45 a.m. registered nurse (RN)-F verified R111's TB symptom screening was completed seven days after admission and stated it should have been completed upon admission. The facility's undated Tuberculosis Control Plan directed staff to administer the first step TST (mantoux) following a symptom screening within the first 72 hours of a resident's admission. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review facility policies and provide education to staff to address the importance of tuberculosis monitoring for residents. The quality assessment and assurance committee could establish a system to audit tuberculosis screening to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426	Compliance will be monitored by Director of Nursing	
21600	MN Rule 4658.1335 Subp. 2 Stock Medications; Emergency Supply Subp. 2. Emergency medication supply. A nursing home may have an emergency medication supply which must be approved by the QAA committee. The contents, maintenance,	21600		12/26/14

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21600	Continued From page 13 and use of the emergency medication supply must comply with part 6800.6700. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the emergency medication kits had a tamper proof seal attached for 1 of 2 emergency kits reviewed. Findings include: On 12/4/14, at 10:17 a.m. Medication Room 230 was reviewed with licensed practical nurse (LPN)-A. At that time the emergency medication kit (eKit) did not have a tamper proof seal on it. The eKit log indicated the last time the eKit was checked by the pharmacist was 10/30/14. The log indicated at that time the tamper proof seal number was #203401. LPN-A stated nursing staff would document on the eKit log after they took a medication out of the eKit, would complete an eKit usage report and fax it to the pharmacy for a refill. LPN-A was observed to apply a tamper proof seal #2023450 on the eKit. At 10:30 a.m. LPN-A stated she contacted the pharmacist and they would be coming to the facility today. LPN-A stated the pharmacist informed her they had not checked the eKit in November due to the Thanksgiving holiday. LPN-A stated she was unsure where the tamper proof seal was that the pharmacist had applied on 10/30/14. The surveyor and LPN-A checked the contents of the eKit against the eKit list. All medications were reconciled.	21600	Director of Nursing has provided education to nurse managers on the re sealing of the ekit. this now is a part of the audit for medications done periodically by the nurse managers. Compliance monitoring will be done by the Director of Nursing	

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21600	Continued From page 14 The Villa St Vincent undated eKit policy indicated the emergency drug supply should all be stored in a container which was sealed. In addition, the pharmacist or pharmacist's agent would seal with a tamper proof seal that must be broken to gain access to the drugs. It is the responsibility of the pharmacist to check the eKit each month. SUGGESTED METHOD OF CORRECTION: The director of nursing could schedule an in-service for nursing staff regarding the re-sealing of the eKit after medications have been used. The quality assessment and assurance committee could randomly audit the eKit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21600		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to provide a dignified, homelike dining experience for 24 of 24 residents (R127, R112, R103, R89, R106, R77, R66, R30, R79, R71,	21805	No plan of correction is needed for this. R127, R112, R103, R89, R106, R77, R71, R108, R64, R101, R80, R6, R91, & R113	12/26/14

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21805	Continued From page 15 R108, R64, R101, R102, R80, R29, R62, R59, R60, R83, R6, R91, R97, R113) residing in the special care unit (dementia unit) who received their meals on trays. Findings include: On 12/1/14, at 5:45 p.m. all 24 residents (R127, R112, R103, R89, R106, R77, R66, R30, R79, R71, R108, R64, R101, R102, R80, R29, R62, R59, R60, R83, R6, R91, R97, R113) were observed in the special care unit dining room. The evening meal arrived in a dietary cart. Staff was observed to deliver a meal tray to each resident that included an insulated plate with a domed cover, as well as cold items and beverages. As each tray was delivered to the resident, the domed cover was removed from the plate and stacked on the table. Each resident was observed to eat their meal from the tray. Subsequent meal observations on the special care unit occurred on 12/2/14, at 8:34 a.m. on 12/3/14, at 8:34 a.m. on 12/3/14, at 12:00 p.m. and on 12/4/14, at 8:35 a.m. During each meal, all residents were observed to be served and eat their meals from the trays. On 12/4/14, at 9:02 a.m. nursing assistant (NA)-B stated the special care unit did not have dietary staff serving meals like they did on the other units. She stated the meals came on the trays so it was just easier to serve the residents their meals on the tray. On 12/04/2014, at 10:33 a.m. NA-C stated the other dining rooms had servers so those meals were dished up and served on a plate, but in the unit, the meals came on trays so they had always served the meals on a tray. NA-C stated that was	21805	are being provided with dignified, homelike dining experience while residing in the special care unit (dementia care). Meals are no longer consumed on the trays. For all other residents who may be affected by this practice an audit was completed in the dining room to be sure all residents' meals are not consumed on a tray. Education has been given to nursing staff that routinely work in the special care unit during meal time. Audits will be completed through the next 6 months and then as needed according to the quality council schedule regarding meals not being consumed on a tray. A policy for meals not being consumed on a tray in the special care unit was revised by the interdisciplinary team. Audit results will be reported to the QA Committee for review and further recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated. The Director of Nursing and Dietary Manager will be responsible for compliance.	

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21805	Continued From page 16 how she was trained and had never done it any differently. On 12/04/2014, at 10:48 a.m. NA-D stated they had always served the meals on the special care unit this way and did not know of any special reason as to why it was done that way. On 12/04/2014, at 1:33 p.m. licensed practical nurse (LPN)-B stated the other dining rooms had servers but the unit was sent their meals on a cart. She indicated they had done it that way for as long as she had worked there. LPN-B stated they needed to load the dishes and trays back into the dietary cart when the residents were done eating so they left the dishes on the trays. On 12/04/2014, at 2:24 p.m. the dietary manager (DM) confirmed they served meals on trays in the special care unit and stated there was no reason to do so. The DM agreed it could be perceived as a dignity issue. A dining policy was requested but none was provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and the Dietary Director could review and revise policies regarding dignified dining related to residents eating meals on trays. The Director of Nurse could in-service staff on providing a dignified dining experience to meet the individual needs of each resident. The Quality assurance committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21805		

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