



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered

September 11, 2024

Administrator  
Villa St Vincent  
516 Walsh Street  
Crookston, MN 56716

Re: Reinspection Results  
Event ID: U7SL12

Dear Administrator:

On September 9, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 31, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
Health Regulation Division  
Telephone: (651) 201-4112  
Email: [Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)





*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
September 11, 2024

Administrator  
Villa St Vincent  
516 Walsh Street  
Crookston, MN 56716

RE: CCN: 245484  
Cycle Start Date: July 31, 2024

Dear Administrator:

On August 20, 2024, we notified you a remedy was imposed. On September 9, 2024 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 2, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 4, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 20, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 4, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 2, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
Health Regulation Division  
Email: [Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)

*An equal opportunity employer.*





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Electronically delivered  
August 9, 2024

Administrator  
Villa St Vincent  
516 Walsh Street  
Crookston, MN 56716

RE: CCN: 245484  
Cycle Start Date: July 31, 2024

Dear Administrator:

On July 31, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections are required.

## REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 31, 2024

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 31, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 31, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction.



The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

**The CMS location may determine to impose other remedies such as a Civil Money Penalty.**

- Civil money penalty. (42 CFR 488.430 through 488.444)

## **NURSE AIDE TRAINING PROHIBITION**

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 31, 2024. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

## **DEPARTMENT CONTACT**

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

Jen Bahr, RN, Regional Operations Supervisor  
Bemidji District Office  
Licensing and Certification Program  
Health Regulation Division  
Minnesota Department of Health  
705 5<sup>th</sup> Street NW, Suite A  
Bemidji, Minnesota 56601-2933  
Email: [Jennifer.bahr@state.mn.us](mailto:Jennifer.bahr@state.mn.us)  
Office: (218) 308-2104



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.

#### **PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

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

#### **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

#### **FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY**

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 January 31, 2025 (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.

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.

#### **APPEAL RIGHTS**

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40,



et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

**[Steven.Delich@cms.hhs.gov](mailto:Steven.Delich@cms.hhs.gov)**

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

**Department of Health & Human Services  
Departmental Appeals Board, MS 6132  
Director, Civil Remedies Division  
330 Independence Avenue, S.W.  
Cohen Building – Room G-644  
Washington, D.C. 20201  
202-795-7490**

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to [Steven.Delich@cms.hhs.gov](mailto:Steven.Delich@cms.hhs.gov).

#### **INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)**

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

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:  
[https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens  
State Fire Safety Supervisor  
Health Care & Correctional Facilities  
MN Department of Public Safety-Fire Marshal Division  
445 Minnesota St., Suite 145  
St. Paul, MN 55101  
Email: [travis.ahrens@state.mn.us](mailto:travis.ahrens@state.mn.us)  
Web: [www.sfm.dps.mn.gov](http://www.sfm.dps.mn.gov)  
Cell: 1-507-308-4189

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
Health Regulation Division  
Telephone: (651) 201-4112  
Email: [Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)



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

PRINTED: 08/26/2024  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245484</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>07/31/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>VILLA ST VINCENT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>516 WALSH STREET</b><br><b>CROOKSTON, MN 56716</b>                           |  |                                                                        |
| (X4) ID<br>PREFIX<br>TAG                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE                                             |
| E 000                                                       | Initial Comments                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | E 000                                                                      |                                                                                                                          |  |                                                                        |
| F 000                                                       | <p>On 7/29/24 through 7/31/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance.</p> <p>INITIAL COMMENTS</p> <p>On 7/29/24 through 7/31/24, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaints were reviewed: H54846204C (MN00104665), H54846205C (MN00102744), H54846206C (MN00104352), H54846305C (MN00105196) and H54846207C (MN00102137) with a deficiency issued at F689 harm, past non-compliance due actions taken by the facility.</p> <p>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.</p> | F 000                                                                      |                                                                                                                          |  |                                                                        |
| F 637<br>SS=D                                               | Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | F 637                                                                      |                                                                                                                          |  | 9/2/24                                                                 |

|                                                                       |       |            |
|-----------------------------------------------------------------------|-------|------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE  |
| Electronically Signed                                                 |       | 08/19/2024 |

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.



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

PRINTED: 08/26/2024  
FORM APPROVED  
OMB NO. 0938-0391

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>VILLA ST VINCENT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>516 WALSH STREET</b><br><b>CROOKSTON, MN 56716</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        |                            |
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| F 637                                                       | <p>Continued From page 1</p> <p>§483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure a significant change in status Minimum Data Set (MDS) was completed as directed for 2 of 2 residents (R64, R296) reviewed for significant change in status.</p> <p>Findings include:</p> <p>R64's quarterly Minimum Data Set (MDS) dated 1/27/24, identified R64 had moderate cognitive impairment and required supervision or touch assistance with toileting hygiene, bed mobility, transfers and ambulation. Diagnoses included dementia, Alzheimer's, repeated falls, heart disease and diabetes.</p> <p>R64's discharge assessment MDS dated 3/28/24, identified R64 required substantial to maximum assist with toileting hygiene, and bed mobility, partial to moderate assist with transfers and ambulation was not attempted.</p> <p>R64's quarterly MDS dated 4/26/24, identified R54 required substantial to maximum assist with</p> |                                                                            |  | F 637                                                                                          | <p>During the survey process it was noted that the facility failed to ensure a significant change in status MDS was completed. It was identified the facility did not have a solid process of identifying, monitoring and implementing a significant change MDS for all residents as R64 &amp; R296 were missed. In June the facility transitioned to 2 MDS nurses to streamline and improve accuracy. The 2 MDS nurses &amp; the IDT have been educated on the elements of a significant change. A spreadsheet has been created as a tracking tool for IDT to identify resident changes for increased monitoring as a means to determine individuals that meet criteria.</p> <p>All residents have the ability to be affected. All residents were audited from the last 2 months to ensure no other additional significant change of status assessments were missed. A significant change MDS will be initiated for any</p> |                                                                        |                            |



|                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                        |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>VILLA ST VINCENT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>516 WALSH STREET</b><br><b>CROOKSTON, MN 56716</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                        |
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| F 637                                                       | <p>Continued From page 2</p> <p>toileting hygiene and bed mobility and was dependent on staff with transfers. R64 was unable to ambulate.</p> <p>R64's quarterly MDS dated 7/24/24, identified R64 was dependent with toileting hygiene, required substantial to maximum assist with bed mobility and was dependent on staff with transfers. R64 was unable to ambulate.</p> <p>When interviewed on 7/31/24, at 10:23 a.m. registered nurse (RN)-C stated she completed R64's MDS when it was due. Licensed practical nurse (LPN)-C notified her when a resident was due for an MDS and also tracked when significant changes needed to be done. RN-C did not track that sort of thing and just followed the list she was provided.</p> <p>During interview on 7/31/24, at 11:22 a.m. LPN-C stated whenever new dependencies were coded a significant change MDS needed to be completed. R64 should have had one done. Therapy had been working with him and so she had not recognized that R64 was no longer ambulating. It was important to complete significant change MDS when changes occur with residents so there was further discussion regarding that resident's care, the care plan was brought up to date and staff were providing care accordingly.</p> <p>When interviewed on 7/31/24, at 2:34 p.m. the director of nursing stated she would have expected a significant change MDS be completed for R64 when he was newly coded dependent with transfers and non ambulatory. It was important to complete the significant change MDS so the resident's care plan was update and</p> | F 637                                                                      | <p>resident identified as meeting the criteria.</p> <p>Education will be provided to nurses who complete the MDS assessments in regards to coding on the MDS by August 30, 2024.</p> <p>Facility policy on comprehensive assessments and care planning was reviewed 8/14/2024 and no revisions were made.</p> <p>To ensure compliance; an audit will be conducted by the MDS coordinator and/or designee on 4 residents per week x 4 weeks and then 2x weekly for 3 months and as needed thereafter to review records for significant changes; results will be reviewed by quality council for monitoring and assured compliance. The DON is responsible for compliance. Facility will achieve substantial compliance by September 2, 2024.</p> |  |                                                                        |



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

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| F 637                                                       | <p>Continued From page 3</p> <p>accurate and staff were providing the care the resident needed.</p> <p>R296's quarterly MDS dated 3/22/24, identified R296 had moderate cognitive impairment and required substantial or maximum assistance with toileting hygiene, dressing, bed mobility and transfers. R296 required partial to moderate assist with ambulation. Diagnoses included dementia, osteoarthritis, anxiety, muscle weakness, kidney disease, heart disease and diabetes.</p> <p>R296's care plan problem with start date 4/23/24, identified a problem with mobility due to R296 was limited with bed mobility, transfers and toileting with goal to receive extensive assistance of one to two people to steady for transfers and toileting and two people to boost up in bed. The newly identified care plan problem with mobility on 4/23/24, indicated the facility was aware of the significant decline with R296's mobility, however, the medical record lacked evidence a significant change assessment had been initiated.</p> <p>R296's Physical Therapy Discharge Summary dated 4/30/24, identified R296 was discharged due to had reached her highest practical level. R296's had participated with therapeutic activities for wheelchair mobility and transfers. Refused to exercise or walk due to back pain with diagnosis of fracture at L1.</p> <p>R296's progress notes 4/1/24 through 5/12/24, identified the following:</p> <p>On 4/1/24, R296 had experienced a fall that resulted in a lumbar fracture.</p> | F 637                                                                      |                                                                                                                          |  |                                                                        |



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| F 637                                                       | <p>Continued From page 4</p> <p>On 4/5/24, physical therapy had evaluated R296 and order received for therapy three times per week.</p> <p>On 5/1/24, R296 was admitted to hospice services.</p> <p>A death in facility MDS tracking record dated 5/12/24, identified R296 expired at the facility under hospice care</p> <p>During interview on 7/31/24, at 11:13 a.m. registered nurse (RN)-C stated she was responsible for completing R296's MDS but was not aware a significant change MDS was needed. LPN-C notified her when MDS were due and if significant changes were needed.</p> <p>When interviewed on 7/31/24, at 11:15 a.m. LPN-C stated she was aware when residents required a significant change at the facility daily interdisciplinary team (IDT) meetings. LPN-C identified a hospice admission would be an automatic reason to complete a significant change MDS, and she had not schedule an MDS assessment. There should have been a significant change MDS assessment completed for R296 with her decline in condition as well as her hospice admission.</p> <p>When interviewed on 7/31/24, at 2:24 p.m. the DON stated she would have expected a significant change MDS assessment to have been completed for R296 related to her decline in mobility as well as her hospice admission. It was important to complete the significant change MDS assessments to identify and capture when a resident has a change for the good or the bad and ensure the staff were providing the care to</p> | F 637                                                                      |                                                                                                                          |  |                                                                        |



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| F 637                                                       | Continued From page 5<br>the resident to meet their needs.<br><br>The facility's undated Comprehensive<br>Assessments and Care Planning policy, identified<br>the RN coordinator with input from the IDT would<br>determine if it was necessary to complete a<br>significant change MDS. A significant change<br>assessment would be appropriate if there were a<br>consistent pattern of changes with two or more<br>areas of decline or improvement or one area that<br>required extensive care plan revision.                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | F 637                                                                      |                                                                                                                          |  |                                                                        |
| F 689<br>SS=G                                               | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains<br>as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate<br>supervision and assistance devices to prevent<br>accidents.<br>This REQUIREMENT is not met as evidenced<br>by:<br>Based on interview and document review, the<br>facility failed to ensure a gait belt was used when<br>transferring/walking 1 of 5 residents (R296)<br>reviewed for falls. This resulted in actual harm for<br>R296 who fell while being transferring and<br>received a lumbar fracture. The facility<br>implemented corrective action prior to the<br>investigation so the deficient practice was issued<br>at past non-compliance.<br><br>Findings include:<br><br>R296's quarterly Minimum Data Set (MDS) dated<br>3/22/24, identified R296 had moderate cognitive | F 689                                                                      | Past noncompliance: no plan of<br>correction required.                                                                   |  |                                                                        |



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| F 689                                                       | <p>Continued From page 6</p> <p>impairment, used a wheelchair or walker with mobility and required maximum assistance with toilet hygiene, transfers and ambulation. Diagnoses included Alzheimer's disease and osteoarthritis.</p> <p>R296's care plan dated 3/4/24, identified R296 was at risk for falls. Interventions included to follow standard fall prevention policy and use walker or wheelchair. Approaches included to ambulate with a full wheeled walker, contact guard assist of one staff with gait belt and wheelchair to follow. R296 was on a scheduled toileting plan and approaches included to offer toileting assistance every morning and bedtime with cares and after the noon meal. Staff were instructed to provide incontinence care after each incontinent episode.</p> <p>R296's Emergency Department Provider Notes dated 4/1/24, identified R296 had a syncopal (fainting) episode while on the toilet and may have hit her head. R296 was taking the medication Eliquis (a blood thinner used to prevent clots) and R296 complained of pain all over. R296 was medicated for pain and returned to the facility with no change in orders.</p> <p>A Nursing Home Incident Report Summary dated 4/2/24, identified R296 had a witnessed fall on 4/1/24, at 12:00 p.m. when staff was assisting R296 in the common bathroom by the dining room. R296 was assisted up from the toilet for staff to assist her with peri care and adjust her clothing. R296 fell on the floor and was unresponsive for approximately ten minutes. R296 was sent to the emergency room (ER) for evaluation and returned to the facility the same day. The following day, R296 was sent to the ER</p> | F 689                                                                      |                                                                                                                          |  |                                                                        |



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| F 689                                                       | <p>Continued From page 7</p> <p>a second time due to reports of continued significant pain. R296 returned to the facility the same afternoon with a diagnoses of lumbar compression fracture.</p> <p>R296's Riverview Health Transfer Note dated 4/2/24, identified R296 had a new diagnosis of lumbar compression fracture and muscle spasms.</p> <p>The invetigative report submitted to the state agency dated 4/8/24, identified nursing assistant (NA)-C stated she was assisting R296 in the bathroom next to the dining room on the memory care unit. R296 stood up from the toilet without problems and NA-C was able to provide peri cares and pull up R296's pants without problem. Then R296 fell forward and hit her head on the safety bar while falling forward. Staff were educated to remain within hands reach at all times and to utilize a gait belt and all staff will participate in the training.</p> <p>R296's progress note(s) identified the following:</p> <ul style="list-style-type: none"><li>- 4/1/24, A fax was sent to R296's primary provider to notify R296 had fell to the floor, hitting her head, when staff were assisting her with toileting hygiene. R296 left the facility by emergency medical services to be evaluated at the ER.</li><li>- 4/2/24. R296 continued to have extreme pain with movement and blood pressure was elevated. R296 was sent to the ER to be evaluated. R296 returned with diagnosis of lumbar fracture and pain medication was ordered.</li><li>- 4/3/24, R296 had pain and discomfort with</li></ul> | F 689                                                                      |                                                                                                                          |  |                                                                        |



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| F 689                                                       | <p>Continued From page 8</p> <p>movement and repositioning. Grimacing and yelling out in pain. Did receive as needed pain medication which was effective for approximately two hours. R296 did not get out of bed and refused both breakfast and lunch.</p> <p>- 4/5/24, A physical therapy evaluation was completed, and therapy ordered three times per week.</p> <p>- 4/8/24, R296 was in bed until mealtime and then did not want to sit for very long. Refused breakfast or to get up for her noon meal. Stated she was in a lot of pain and would holler out in distress with movement of any kind.</p> <p>- 4/27/24, R296 had been in bed most of shift. R296 did go out for supper but refused to eat anything. R296 took some of her scheduled medications along with as needed medication for back pain which was effective.</p> <p>- 5/1/24, R296 was evaluated for hospice and admitted to hospice services with primary diagnosis of Alzheimer's disease.</p> <p>- 5/12/24, R296 passed away with her family at her bed side.</p> <p>When interviewed on 7/29/24, at 6:30 p.m. family member (FM)-D stated R296 had been on hospice at the facility and expired. A staff member had taken her to the bathroom, and she fell, hitting her head, and had gone downhill after her fall.</p> <p>During interview on 7/31/24, at 9:39 a.m. nursing assistant (NA)-A stated she always used a gait</p> |                                                                            |  | F 689                                                                                          |                                                                                                                          |                                                                        |                            |



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| F 689                                                       | <p>Continued From page 9</p> <p>belt when walking or transferring patients. She remembered R296 transferred and ambulated with assist but would take off on her own sometimes.</p> <p>When interviewed on 7/31/24, at 9:53 a.m. NA-B stated R296 was assist of one with toileting and she had never noticed her trying to go to the bathroom on her own. NA-B always used a gait belt with transfers and when assisting anyone to ambulate.</p> <p>During interview on 7/31/24, at 10:00 a.m. registered nurse (RN)-C stated she was working when R296 fell. RN-C heard R296 fall and rushed into the bathroom to see what happened. RN-C found NA-C standing frozen and R296 was lying flat on her back with her head close to the door that was opposite of the toilet, her body at an angle with her feet between the toilet and sink. NA-C was standing between the toilet and R296. R296 was unresponsive and did not have a gait belt on. RN-C called for help and 911 was called. When R296 returned from the ER, no imaging had been done on her back. The following day RN-C sent her back in due to extreme pain and then they found the fracture in her back, which was a new fracture. RN-C thought NA-C could possibly have caught R296 as she fell backward and possibly slowed or prevented her fall if she had been using a gait belt with the transfer.</p> <p>When interviewed on 7/31/24, at 2:24 p.m. the director of nursing (DON) stated it was her understanding that a gait belt had not been in use when assisting R296 with toileting just prior to her fall and R296 had a syncope episode and fell, and a gait belt was not in use. Staff were expected to use a gait belt whenever there was</p> | F 689                                                                      |                                                                                                                          |  |                                                                        |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>VILLA ST VINCENT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>516 WALSH STREET</b><br><b>CROOKSTON, MN 56716</b>                           |  |                                                                        |
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| F 689                                                       | Continued From page 10<br><br>hands on assist with any transfer or ambulation.<br>After the investigation of the fall staff, including<br>the NA involved were educated on signs and<br>symptoms of syncope and interventions to use as<br>well as use of a gait belt with transfer and<br>ambulation.<br><br>Observation of other residents transferring and<br>ambulating were observed during the course of<br>the survey and all staff utilized the transfer belt as<br>appropriate. Staff interviews identified staff knew<br>when to use a gait belt.<br><br>The facility policy Transfer Belt dated 7/11/19,<br>identified staff were to review the resident's care<br>plan or assignment sheet for the resident's<br>transfer and ambulation status. Fasten the<br>transfer belt around the resident's waist, allow the<br>resident to get and maintain balance after<br>assisting to stand and ambulate resident with<br>grasp on transfer belt at the resident's back, until<br>assisting resident back to a sitting position. | F 689                                                                      |                                                                                                                          |  |                                                                        |
| F 756<br>SS=D                                               | Drug Regimen Review, Report Irregular, Act On<br>CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident<br>must be reviewed at least once a month by a<br>licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review<br>of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any<br>irregularities to the attending physician and the<br>facility's medical director and director of nursing,<br>and these reports must be acted upon.<br>(i) Irregularities include, but are not limited to, any                                                                                                                                                                                                                                                                                                                                                                                                                          | F 756                                                                      |                                                                                                                          |  | 9/2/24                                                                 |



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| F 756                                                       | <p>Continued From page 11</p> <p>drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.</p> <p>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.</p> <p>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</p> <p>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure the provider documented a thorough rationale for continued use of medications for 1 of 5 residents (R64) reviewed for unnecessary medication use.</p> <p>Findings include:</p> <p>R64's undated Active Orders report identified R64 had current physician orders for sertraline (an antidepressant medication) 50 milligrams (mg) every morning with start date 10/21/22. A previous order for trazadone (an antidepressant</p> | F 756                                                                      | <p>During the survey process it was noted that the facility failed to ensure the provider documented a thorough rationale for continued use of medications. The facility has been diligently working with providers with regards to appropriate responses to pharmacy recommendations. Information had been provided on the regulations around GDR attempts and required provider rationale necessary when contraindicated. Currently a new pharmacy recommendation is sent back to the</p> |  |                                                                        |



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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| F 756                                                       | <p>Continued From page 12</p> <p>medication) 50 mg one-half tablet every bedtime, had been ordered with start date 10/20/22, and discontinued date 3/26/24.</p> <p>R64's Consultant Pharmacist Recommendation to Physician dated 8/24/23, identified the consulting pharmacist (CP) identified R64 was receiving sertraline 50 mg and trazadone 25 mg every day. R64's medical record lacked evidence of depression symptoms. The CP recommended according to practice guidelines; a trial reduction may be reasonable. R64's primary physician responded, continue antidepressant therapy, a dose reduction was contraindicated and to see progress note below or in chart with no further notation.</p> <p>R64's medical record was reviewed and lacked any other documentation or dictation from R64's provider regarding the justification of continued use of the antidepressant medications.</p> <p>When interviewed on 7/31/24 at 10:23 a.m., registered nurse (RN)-C stated R64's trazadone was stopped in March because a narcotic had been ordered. RN-C would have to talk to R64's primary provider about the need for rationale to deny a gradual dose reduction for his antidepressant medications. RN-C was not aware it was ever brought up again since the pharmacist made the recommendation in August the previous year. When the physician sends back something indicating no changes, she never questioned it. The director of nursing (DON) had a recent meeting with the providers group and the need to address pharmacist recommendations and provide rationale for dosing decisions was brought up to them as it was recognized as a problem for the facility.</p> |                                                                            |  | F 756                                                                                          | <p>provider when rationale provided does not meet the requirements. If a provider has not responded within 2 to 3 months an additional recommendation is sent to the provider. Currently the DON reviews &amp; monitors all pharmacy recommendations requests to ensure an appropriate response is received. A new copy of the recommendation is provided to the appropriate provider when the response does not meet the requirements. Psychotropic medication review mtgs are being conducted and results are reported to the Medical Director as well as QAPI.</p> <p>All residents have the ability to be affected by this deficient practice. All pharmacist to physician reports for GDRs for the last 2 months were reviewed to ensure thorough rationale was indicated and if not, was sent back to the provider for further rationale.</p> <p>The PCP for R64 was contacted to review antidepressant medication use. The provider dictated note received on 8/20/24, stated a GDR attempt of Zoloft was declined at this time due to recent stressors and mental health changes over the past year. R64 has had a recent reduction in Seroquel dose. Decreasing Zoloft at this time would potentially cause harm to the resident.</p> <p>Education will be provided to all attending physicians on what an acceptable thorough rationale would include as provided by the consultant pharmacist on or by August 30, 2024.</p> |                                                                        |                            |



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| F 756                                                       | <p>Continued From page 13</p> <p>When interviewed on 7/31/24 at 2:34 p.m., the DON stated usually when CP-E made recommendations that were not properly addressed, he would send follow up recommendations the following month. The facility had been having some struggles with certain providers addressing the pharmacy recommendations. The DON had just met with the providers the previous month and physician response to pharmacy recommendations was discussed. The DON felt the providers had a better understanding of the issues and were now aware of what the facility expectations were.</p> <p>During telephone interview on 7/31/24 at 3:00 p.m., CP-E stated he had made recommendations to taper R64's antidepressant medications in August 2023. CP-E usually brings the issue up every few months when a provider declines a recommendation. R64 had experienced a number of falls and medication changes in March 2024 and so by the time he was going to readdress the issue with the provider again, the antidepressant medications were the least of his worries. CP-E verified the time between his recommendations in August until R64 had change in condition was seven months.</p> <p>On 7/31/24 at 3:27 p.m., a telephone interview was attempted with the medical director (MD)-F with no answer. A message was left for return call.</p> <p>On 8/1/24 at 3:15 p.m., MD-F returned call. MD-F stated he was aware of the issues with some of the primary providers failing to respond adequately to pharmacist recommendations. It</p> | F 756                                                                      | <p>To ensure compliance; an audit on pharmacist to physician recommendations with rationale will be conducted by the DON and/or designee on 4 residents per month x 4 months and then 2x residents for 3 months and as needed thereafter; results will be reviewed by quality council for monitoring and assured compliance. The DON is responsible for compliance. Facility will achieve substantial compliance September, 2, 2024.</p> |                            |                                                                        |



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| F 758<br>SS=D                                               | <p>had been discussed during the last quality assurance performance improvement (QAPI) meeting and the pharmacist had provided a list of the providers who frequently did not address medications recommendations. MD-F was planning to set up a meeting with the providers to find out what the issues were and why they were not responding appropriately to the pharmacist recommendations.</p> <p>Free from Unnec Psychotropic Meds/PRN Use<br/>CFR(s): 483.45(c)(3)(e)(1)-(5)</p> <p>§483.45(e) Psychotropic Drugs.<br/>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br/>(i) Anti-psychotic;<br/>(ii) Anti-depressant;<br/>(iii) Anti-anxiety; and<br/>(iv) Hypnotic</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that---</p> <p>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> | F 758                                                                      |                                                                                                                          | 9/2/24                     |                                                                        |



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| F 758                                                       | <p>Continued From page 15</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and document review, the facility failed to ensure there was a process to ensure a gradual dose reduction (GDR) or adequate medical justification documented for psychotopic medications was implemented for for 1 of 5 residents (R64) reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>R64's quarterly Minimum Data Set (MDS) dated 7/24/24, identified R64 had moderate cognitive impairment and R64's mood interview did not identify syptoms of depression. R64 received antidepressant medication on a daily basis.</p> <p>R64's undated Active Orders report identified R64</p> |                                                                            |  | F 758                                                                                          | <p>During the survey process it was noted that the facility failed to ensure there was a process to ensure GDR/adequate medical justification was available in the medical record. The facility has been diligently working with providers with regards to appropriate responses to pharmacy recommendations. Information had been provided on the regulations around GDR attempts and required provider rationale necessary when contraindicated. Currently a new pharmacy recommendation is sent back to the provider when rationale provided does not meet the requirements. If a provider has not responded within 2 to 3 months an additional recommendation is</p> |                                                                        |                            |



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| F 758                                                       | <p>Continued From page 16</p> <p>had current physician orders for sertraline (an antidepressant medication) 50 milligrams (mg) every morning with start date 10/21/22. A previous order for trazodone (an antidepressant medication) 50 mg one-half tablet every bedtime, had been ordered with start date 10/20/22, and discontinue date 3/26/24.</p> <p>R64's Consultant Pharmacist Recommendation to Physician dated 8/24/23, identified the consulting pharmacist (CP) identified R64 was receiving sertraline 50 mg and trazadone 25 mg every day. R64's medical record lacked evidence of depression symptoms. The CP recommended according to practice guidelines; a trial reduction may be reasonable. R64's primary physician responded, continue antidepressant therapy, a dose reduction was contraindicated and to see progress note below or in chart with no further notation.</p> <p>R64's medical record was reviewed and lacked any other documentation or dictation from R64s provider regarding the justification of continued use of the antidepressant medications.</p> <p>On 7/30/24, at 9:42 a.m. R64 was lying in bed watching television. R64 was fully dressed and groomed and stated he had already been up for his breakfast and now returned to bed. R64 was pleasant and smiling.</p> <p>When interviewed on 7/31/24 at 10:23 a.m., registered nurse (RN)-C stated R64's trazadone was stopped in March because a narcotic had been ordered. RN-C would have to talk to R64's primary provider about the need for rationale to deny a gradual dose reduction for his antidepressant medications. RN-C was not aware</p> |                                                                            |  | F 758                                                                                          | <p>sent to the provider. Currently the DON reviews &amp; monitors all pharmacy recommendations requests to ensure an appropriate response is received. A new copy of the recommendation is provided to the appropriate provider when the response does not meet the requirements. Psychotropic medication review mtgs are being conducted and results are reported to the Medical Director as well as QAPI.</p> <p>All residents who receive antidepressants have the ability to be affected by this deficient practice. Residents with an active diagnosis of depression will be reviewed for depression symptoms. No other residents have been affected.</p> <p>The facility will reinstate the internal psychotropic med monitoring committee to ensure residents have appropriate diagnosis, monitoring, consents, and address GDR's to meet the requirements. Meetings will occur at least twice a quarter.</p> <p>Education will be provided to all attending physicians and nurse managers on GDR requirements and what an acceptable thorough rationale would include as provided by the consultant pharmacist on or by August 30, 2024.</p> <p>Facility policy on GDRs was reviewed on 8/14/2024 and no revisions were made. To ensure compliance; an audit on pharmacist to physician recommendations with rationale will be conducted by the</p> |                                                                        |                            |



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| F 758                                                       | <p>Continued From page 17</p> <p>it was ever brought up again since the pharmacist made the recommendation in August the previous year. When the physician sends back something indicating no changes, she never questioned it. The director of nursing (DON) had a recent meeting with the providers group and the need to address pharmacist recommendations and provide rationale for dosing decisions was brought up to them as it was recognized as a problem for the facility. RN-C did not identify what the nursing process was to address GDR's or a rationale from the provider.</p> <p>When interviewed on 7/31/24 at 2:34 p.m., the DON stated usually when CP-E made recommendations that were not properly addressed, he would send follow up recommendations the following month. The facility had been having some struggles with certain providers addressing the pharmacy recommendations. The DON had just met with the providers the previous month and physician response to pharmacy recommendations was discussed. The DON felt the providers had a better understanding of the issues and were now aware of what the facility expectations were. DON did not identify what the nursing process was to address GDR's or a rationale from the provider outside of the CP-E's recommendations.</p> |                                                                            |  | F 758                                                                                          | <p>DON and/or designee on 4 residents per month x 4 months and then 2x residents for 3 months and as needed thereafter; results will be reviewed by quality council for monitoring and assured compliance. The DON is responsible for compliance. Facility will achieve substantial compliance September 2, 2024.</p> |                                                                        |                            |
| F 761<br>SS=D                                               | <p>Label/Store Drugs and Biologicals</p> <p>CFR(s): 483.45(g)(h)(1)(2)</p> <p>§483.45(g) Labeling of Drugs and Biologicals</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |  | F 761                                                                                          |                                                                                                                                                                                                                                                                                                                       |                                                                        | 9/2/24                     |



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| F 761                                                       | <p>Continued From page 18</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and document review the facility failed to ensure medications were safely and securely stored for 1 of 1 resident (R70) reviewed for medication storage.</p> <p>Findings include:</p> <p>R70's quarterly Minimum Data Set (MDS) dated 6/22/24, identified R70 had moderate cognition and required assistance with activities of daily living (ADL)'s. R70's diagnoses included stage IV pressure ulcers of the sacral region, right hip and left hip, and type 2 diabetes.</p> |                                                                            |  | F 761                                                                                          | <p>During the survey process it was noted that the facility failed to ensure medications were safely and securely stored. The facility failed to provide clear direction to staff on how manage use of wound supplies for residents on EBP.</p> <p>The Dakin solution and the Nystatin powder was removed from R70's room on 8/18/24 and an order has been obtained for the use of Nystatin powder.</p> <p>All residents have the ability to be affected</p> |                                                                        |                            |



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| F 761                                                       | <p>Continued From page 19</p> <p>During observation on 7/30/24 at 4:18 p.m., Vashe (Dakin's) solution wound cleanser and Nystatin powder (an antifungal medication used to treat infections) were sitting on the dresser in R70's room.</p> <p>R70's undated physicians order report included Dakin's 0.125% wound cleansing solution. The report failed to include orders for Nystatin powder.</p> <p>R70's medical record lacked assessment and care plan to have medications stored at the bedside.</p> <p>During interview on 7/30/24 at 4:18 p.m., R70 stated the medications were always left on the dresser in her room and the nurses use the medications for her dressing change. R70 was uncertain of the medication's names.</p> <p>On 7/31/24 at 10:05 a.m., licensed practical nurse (LPN)-A stated R70 had a current order for wound cleanser solution, however, there were no current orders for Nystatin powder. Further, LPN-A stated the medications should not be left in R70's room in an unsecured area.</p> <p>On 7/31/24 at 10:32 a.m., registered nurse (RN)-A stated she was aware of the unsecured medications left in R70's room. RN-A stated medications left in a resident's room should be in a secured and safe place that is out of reach to residents.</p> <p>The Self-Administration of Medications policy dated 2/19, identified medications self-administered medications must be stored in a</p> |                                                                            |  | F 761                                                                                          | <p>by this deficient practice. A room audit was conducted of all resident rooms to review for medications left at the bedside. Medications have been removed and stored properly.</p> <p>Education will be provided to all associated staff on or before August 30, 2024 on proper medication storage and resident assessments/physician orders.</p> <p>To ensure compliance; an audit on resident rooms specific to medications at the bedside and physician orders will be conducted by the DON and/or designee on 5 residents per week x 4 weeks and then 3 residents weekly for 3 months and as needed thereafter; results will be reviewed by quality council for monitoring and assured compliance. The DON is responsible for compliance. Facility will achieve substantial compliance September 2, 2024.</p> |                                                                        |                            |



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| F 773<br>SS=D                                               | <p>safe and secure place, which is not accessible y<br/>other residents. If safe storage is not possible,<br/>the medications will be stored on a central<br/>medication cart or in the medication room.</p> <p>Lab Srvcs Physician Order/Notify of Results<br/>CFR(s): 483.50(a)(2)(i)(ii)</p> <p>§483.50(a)(2) The facility must-</p> <p>(i) Provide or obtain laboratory services only when<br/>ordered by a physician; physician assistant; nurse<br/>practitioner or clinical nurse specialist in<br/>accordance with State law, including scope of<br/>practice laws.</p> <p>(ii) Promptly notify the ordering physician,<br/>physician assistant, nurse practitioner, or clinical<br/>nurse specialist of laboratory results that fall<br/>outside of clinical reference ranges in accordance<br/>with facility policies and procedures for<br/>notification of a practitioner or per the ordering<br/>physician's orders.</p> <p>This REQUIREMENT is not met as evidenced<br/>by:</p> <p>Based on interview and document review, the<br/>facility failed to provide timely INR (a<br/>standardized measurement of how long it takes<br/>the blood to clot) level results for a resident on<br/>warfarin sodium (a blood thinning medication) for<br/>1 of 2 resident (R52) reviewed who were taking<br/>warfarin.</p> <p>Findings include:</p> <p>R52's quarterly Minimum Data Set (MDS) dated<br/>5/1/24, identified R52 had diagnoses that<br/>included end stage renal disease, heart failure<br/>and vascular disease. R52 used anticoagulant<br/>medication (blood thinner).</p> | F 773                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 9/2/24                                                                 |
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| F 773                                                       | <p>Continued From page 21</p> <p>R52's care plan revised 6/27/24, identified R52 had a pacemaker (a small device that's placed (implanted) in your chest to help control your heartbeat). Staff were directed to observe R52 for complaints of dizziness, arrhythmia (irregular heartbeat), bradycardia (slow heartbeat), tachycardia (fast heartbeat), chest pain, syncope, and dyspnea (shortness of breath). R52 was on dialysis (a type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to) related to end stage renal disease. Staff were directed to administer medications as ordered and draw labs per order. Staff were directed to report lab abnormalities promptly.</p> <p>R52's physician orders identified the following:</p> <ul style="list-style-type: none"><li>- On 1/26/24, warfarin (a blood thinner that reduces the formation of blood clots. Warfarin is used to treat or prevent blood clots in veins or arteries, which can reduce the risk of stroke, heart attack, or other serious conditions.) 3 milligrams (mg) by mouth once a day in the evening.</li><li>- On 7/29/24, INR special instructions: send results to R52's medical provider for paroxysmal atrial fibrillation (the most common type of irregular heartbeat that often causes the heart to beat too quickly. One of the biggest concerns with AFib is the risk of stroke. In fact, people with AFib have about 5 times greater risk of stroke than those who do not have AFib).</li></ul> <p>R52's nursing progress notes identified the following:</p> <p>On 5/29/24 at 12:13 p.m., R52's INR result was 2.1. The results were faxed to R52's medical provider.</p> <p>On 6/10/24 at 11:24 a.m., nursing reviewed R52's</p> | F 773                                                                      | <p>residents on coumadin have been audited to ensure proper notification of the most recent INR lab was provided. R52 was the only resident effected by the deficient practice. The PCP, RiverView Clinic and the facilities Medical Director have been informed of the facilities expectation regarding an appropriate response time regarding INR results. R52's PCP has been contacted and specific orders provided.</p> <p>Education will be provided to all licensed nurses on timely notification of lab results to the provider. The facility's process on INR communication was reviewed and revised on 8/14/2024 date and the new process was educated to licensed nurses on or by August 30, 2024.</p> <p>To ensure compliance; an audit on PT/INR results and notification to the provider will be conducted by the DON and/or designee on 2 residents per week who have INR labs ordered x 4 weeks and then 2x weekly for 3 months and as needed thereafter; results will be reviewed by quality council for monitoring and assured compliance. The DON is responsible for compliance. Facility will achieve substantial compliance by September 2, 2024.</p> |  |                                                                        |



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| F 773                                                       | <p>Continued From page 22</p> <p>clinic documentation for an INR reading of 2.1 on 5/29/24. Per R52's medical provider, recheck INR in one month.</p> <p>On 6/27/24 at 10:34 a.m., R52's INR result was 1.9. The results were faxed to R52's medical provider.</p> <p>On 6/28/24 at 6:59 a.m., per R52's medical provider regarding R52's 6/27/24 INR, "recheck in 1 month. No changes"</p> <p>On 7/29/24 at 1:00 p.m.[Recorded as Late Entry on 7/30/24 at 7:41 a.m.] R52's INR result was 1.5.</p> <p>An email dated 7/30/24 at 7:48 a.m., identified registered nurse (RN)-C scanned and emailed R52's 7/29/24 INR result to R52's medical provider. A response from R52's medical provider office dated 7/30/24 at 5:09 p.m., identified R52's medical provider reviewed R52's INR result. An INR check was ordered for one week with no changes in warfarin dose.</p> <p>R52's Coagulation Facsimile Transmittal dated 7/30/24, identified R52's INR result that day was 1.5. The form did not identify the INR sample had been collected on 7/29/24, what R52's INR goal range was, nor that R52's result was sub-therapeutic.</p> <p>During an interview on 7/31/24 at 9:53 a.m., trained medication aide (TMA)-A stated she did not do anything with obtaining an INR. The nurses took care of all that. When a resident was due to have an INR obtained, the order was on the nurses' treatment sheets.</p> <p>During an interview on 7/31/24 at 10:02 a.m., licensed practical nurse (LPN)-B stated only the unit managers took care of resident INR orders</p> | F 773                                                                      |                                                                                                                          |  |                                                                        |



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| F 773                                                       | <p>Continued From page 23</p> <p>and she did not do anything besides administer the medication.</p> <p>During an interview on 7/31/24 at 10:03 a.m., registered nurse (RN)-B stated when a resident was admitted or started on warfarin, an order was placed into the resident's electronic medical record (EMR). The facility used a PT/INR meter in the facility to collect an INR. Once the result was obtained, it was faxed to either the Coumadin Clinic or the resident's medical provider. The facility used a spreadsheet to track residents' results as well. Staff were expected to receive a response from the medical provider or Coumadin Clinic the same day. If the response was not received and the result "out of range", then the nurse was expected to contact either the emergency room or the medical provider on-call. If the INR was in range and the response not received, the nurse may use discretion and contact the medical provider the following day. RN-B stated she was unfamiliar with R52 and was unable to determine what R52's goal range was by R52's EMR.</p> <p>During an interview on 7/31/24 at 10:39 a.m., RN-C stated she "just did" R52's INR on Monday 7/29/24. R52's INR goal range was 2.0-3.0 because R52 had atrial fibrillation. For R52, the result was always sent to R52's medical provider. RN-C would get the reading then fax the result to the medical provider, but also was able to scan the result and email it for a faster response. When the response was received, RN-C would schedule the next INR and also update the pharmacy if there was a change in medication and would update the warfarin spreadsheet as well. There was a Coagulation Facsimile Transmittal form that could be filled out and faxed</p> |                                                                            |  | F 773                                                                                          |                                                                                                                          |                                                                        |                            |



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| F 773                                                       | <p>Continued From page 24</p> <p>as well. The form included resident demographics, the INR result and also included additional information such as the resident's goal range, and changes in condition such as an antibiotic that may influence the medical provider's decisions. RN-C stated she did get a response on Monday 7/29/24, but just forgot to enter it into the EMR. RN-C stated the INR was collected on 7/29/24, as ordered, but faxed to the medical provider on 7/30/24. When RN-C had to call R52's medical provider, it could be difficult. R52's medical provider was hard to reach and even more difficult to get a response from. RN-C received a response from R52's medical provider by email on 7/30/24, at 5:00 p.m. and put in the order for the next INR at that time but did not document in a nursing note. However, RN-C stated she did not attempted to determine why R52's INR was 1.5 such as missed doses and/or diet changes. RN-C stated a subtherapeutic result potentially could place a resident at risk for a blood clot or stroke.</p> <p>During an interview on 7/31/24 at 3:05 p.m., assistant director of nursing (ADON) stated the facility used a PT/INR meter to obtain resident INR results. When the result was obatined it woud be sent to either the Coumadin Clinic or the resident's medical provider, it just depended on the resident. Sometimes, the medical providers were "pokey" about getting order back to the facility and nursing had to refaxed and/or call for a couple days. Staff were expected to receive a response the same day and should call the medical provider each day until a response was received. If in range, a response was expected within a day or so. However, if the INR result was out of range and/or critical, nursing needed to call the medical provider on-call and get orders. R52's</p> | F 773                                                                      |                                                                                                                          |  |                                                                        |



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| F 773                                                       | <p>Continued From page 25</p> <p>INR result on 1.5 on 7/29/24, should have been addressed by R52's medical provider and, if not, the medical provider on-call should have been contacted. However, the ADON stated she was unsure what the facility policy directed. Anytime an INR was below therapeutic range, the resident was at risk for clots, however, the staff were unable to control how/when the medical providers responded to communications. The ADON was unsure what the unit managers did in terms of investigation into out of range INR results. The ADON stated they had addressed these concerns with the medical director and were trying to set up a meeting to address this concern.</p> <p>During an interview on 7/31/24 at 3:22 p.m., the director of nursing (DON) stated INR results were expected to be provided to the medical provider the same day they were collected whether by fax, email or call. An out of range result, should be called in to the medical provider. Warfarin was a high risk medication and it needed to be addressed timely so it should always be a phone call with a response received the same day. If out of range, it placed the resident at risk for bleeding and/or a clot/stroke. The DON stated she would not expect a floor nurse to investigate why a resident's INR result was out of range, but expected the unit managers to do so. Staff had ever reported to her a difficulty regarding communication response regarding warfarin or INRs specifically, but had addressed difficulty getting responses for faxed communication. The medical director had been informed of those difficulties but had not responded.</p> <p>During a phone interview on 8/1/24 at 3:15 p.m., the facility medical director stated he was not happy with the fax system. Currently, someone</p> |                                                                            |  | F 773                                                                                          |                                                                                                                          |                                                                        |                            |



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| F 773                                                       | Continued From page 26<br><br>had to go and get the faxed document from the<br>fax machine and place the document on the<br>correct provider's desk and was inefficient.<br>Guidelines directing staff when to contact the<br>provider regarding INR results needed to be<br>implemented. The medical director stated he<br>expected nursing to contact the medical provider<br>when the INR was out of range.<br><br>The facility policy Coagucheck/INR Meter<br>Specimen Collection undated, identified the<br>procedure for sample collection and<br>unacceptable specimens. However, the policy did<br>not address the timely reporting of INR results<br>and/or directed staff what to do when a response<br>was not received.                                                                                                                          | F 773                                                                      |                                                                                                                          |  |                                                                        |
| F 880<br>SS=D                                               | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an<br>infection prevention and control program<br>designed to provide a safe, sanitary and<br>comfortable environment and to help prevent the<br>development and transmission of communicable<br>diseases and infections.<br><br>§483.80(a) Infection prevention and control<br>program.<br>The facility must establish an infection prevention<br>and control program (IPCP) that must include, at<br>a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying,<br>reporting, investigating, and controlling infections<br>and communicable diseases for all residents,<br>staff, volunteers, visitors, and other individuals<br>providing services under a contractual | F 880                                                                      |                                                                                                                          |  | 9/2/24                                                                 |



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| F 880                                                       | <p>Continued From page 27</p> <p>arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens.<br/>Personnel must handle, store, process, and</p> |                                                                            |  | F 880                                                                                          |                                                                                                                          |                                                                        |                            |



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PRINTED: 08/26/2024  
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OMB NO. 0938-0391

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| F 880                                                       | <p>Continued From page 28</p> <p>transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review.<br/>The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview and document review the facility failed to ensure enhanced barrier precautions (EBP) were utilized with residents with a catheter for 2 of 2 residents (R1, R69) reviewed for catheters.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS) dated 5/15/24, identified R1 had severe cognitive impairment and had an indwelling catheter. R1's undated Facesheet identified diagnoses of chronic kidney disease and urinary retention.</p> <p>R1's care plan dated 6/11/24, identified R1 had a catheter and included interventions to manage the catheter; however, the care plan failed to identify if R1 was on EBP and when EBP was to be used.</p> <p>On 7/29/24 5:32 p.m. R1 was observed lying in bed and had a catheter leg bag attached to his right leg and was draining yellow urine. The was no personal protective equipment (PPE) cart in or outside R1's room and there was nothing on the door or elsewhere identifying R1 was on EBP.</p> <p>On 7/30/24 at 9:46 a.m., R1 was seated on the bed and nursing assistant (NA)-D was observed emptying the leg bag to the catheter. NA-D was wearing gloves; however, did not have a gown</p> |                                                                            |  | F 880                                                                                          | <p>During the survey process it was noted that the facility failed to ensure EBP were utilized with residents with a catheter. The facility failed to ensure staff had a clear understanding of EBP requirements. Going forward the IP nurse will be the only one to give direction to removed EBP from a resident room.</p> <p>All residents who have a catheter have the ability to be affected by this deficient practice. All residents with catheters. Reviewed. No other residents were affected by the deficient practice. EBP were replace for R1 &amp; R69 on 7/30/2024.</p> <p>Education will be provided to associated nursing staff on or before August 30, 2024 on the EBP policy.</p> <p>To ensure compliance; an audit on all residents with catheters to ensure EBP are in place will be conducted by IP weekly x 4 months and as needed thereafter; results will be reviewed by quality council for monitoring and assured compliance. The DON is responsible for compliance. Facility will achieve substantial compliance by September 2, 2024.</p> |                                                                        |                            |



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| F 880                                                       | <p>Continued From page 29</p> <p>on. NA-D finished emptying the catheter, cleansed the port with alcohol, emptied the urine, removed their gloves and sanitized their hands and exited the room.</p> <p>During interview on 7/30/24 9:48 a.m., NA-D could not state if they were to wear a gown when emptying the catheter for R1 and would have to ask.</p> <p>R69's quarterly MDS 6/20/24, identified R1 had moderate cognitive impairment and had an indwelling catheter. R69's undated Facesheet identified a diagnosis of urethral stricture.</p> <p>R69's care plan dated 5/30/24, identified R69 had a catheter and included interventions to manage the catheter; however, the care plan failed to identify if R69 was on EBP and when EBP was to be used.</p> <p>On 7/29/24 12:52 at p.m. R69 was observed seated in his wheelchair and had a catheter leg bag attached to his right leg and draining yellow. There was no PPE cart in or outside R69's room and there was nothing on the door or elsewhere identifying R69 was on EBP.</p> <p>On 7/30/24 at 10:36 a.m. R69 was not in his room and there continued to be no PPE cart in or outside R69's room and there was nothing on the door or elsewhere identifying R69 was on EBP.</p> <p>On 7/30/24 at 11:32 a.m. NA-E was observed placing a PPE cart outside R69's room.</p> <p>During interview on 7/30/24 at 11:32 a.m. NA-E stated she was placing the cart for EBP outside R69's room as R69 was supposed to be on EBP</p> |                                                                            |  | F 880                                                                                          |                                                                                                                          |                                                                        |                            |



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| F 880                                                       | <p>Continued From page 30</p> <p>because he had a catheter. There had not been PPE carts for R69 or R1 and none of the staff had been wearing gowns while providing care for the R69 and R1 while in their rooms.</p> <p>During interview on 7/30/24 at 11:36 a.m. registered nurse (RN)-B, who was also the facility infection preventionist, stated her understanding was EBP was more of a suggestion and then all of a sudden it was implemented. Other residents in the facility had EBP however, RN-B could not explain why R1 and R69, who resided on the memory care unit, did not have the EBP implemented. RN-B stated EBP was to be used with any residents that had an external line like a catheter and with chronic wounds.</p> <p>When interviewed in 7/30/24 at 11:40 a.m. stated R1 had a catheter for some time and R69 had got a new indwelling catheter placed a couple weeks ago. RN-B could not identify why EBP were not implemented for R1 and R69.</p> <p>The facility policy Enhanced Barrier Precautions dated 3/28/24, identified EBP was a strategy in nursing homes to decrease the transmission of multi drug resistant organisms (MDR)). EBP would be used for residents actively infected or colonized with an MDRO along with those with an indwelling medical device and or chronic wounds requiring a dressing would be required to use EBP. EBP should be used during high contact resident care activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs/toileting, indwelling medical care device including central line/urinary catheter/feeding tube/tracheotomy/ventilator and with any chronic wound care.</p> |                                                                            |  | F 880                                                                                          |                                                                                                                          |                                                                        |                            |



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| F 883<br>SS=E                                               | <p>Influenza and Pneumococcal Immunizations<br/>CFR(s): 483.80(d)(1)(2)</p> <p>§483.80(d) Influenza and pneumococcal immunizations<br/>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is</p> | F 883                                                                      |                                                                                                                          | 9/2/24                     |                                                                        |



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| F 883                                                       | <p>Continued From page 32</p> <p>medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure recommended pneumococcal vaccinations, as outlined by the Centers for Disease Control (CDC), were offered and/or provided in a timely manner to reduce the risk of severe disease for 4 of 5 residents (R3, R13, R70, R72) reviewed for immunizations.</p> <p>Findings include:</p> <p>R3's admission Face Sheet dated 4/22/24, identified R3's age of 84 years. Diagnoses included cerebral infarction (stroke), thrombocytopenia (low platelet count that could cause bleeding), endocrine disorder and malignant neoplasm of prostate (cancer)/</p> <p>R3's Minnesota Immunization Information Connection (MIIC) report dated 12/15/23, identified R3's immunizations. R3 received the pneumococcal polysaccharide vaccine (PPSV23) 11/13/06, the pneumococcal vaccine Prevnar 13</p> | F 883                                                                      | <p>During the survey process it was noted that the facility failed to ensure recommended pneumococcal vaccines as outlined by the CDC were offered and/or provided in a timely manner. The facility failed to have a clear transition between IP staff and clear expectations of unit managers role in the vaccine process. The IP nurse will ensure that R3, R13, R70, R72 vaccine process is completed by 8/30/2024.</p> <p>All pneumococcal eligible residents have the ability to be affected by this deficient practice. All resident charts will be audited to identify those who are eligible for a pneumococcal vaccine. If any residents are currently eligible for a pneumococcal vaccine; consents and education will be provided to them to offer the eligible vaccine.</p> |  |                                                                        |



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| F 883                                                       | <p>Continued From page 33</p> <p>(PCV13) on 7/1/15. R3's immunization record lacked evidence any other pneumococcal vaccinations, including the newer recommended pneumococcal conjugate (PCV 15 or PCV 20) had been offered in conjunction with their providers recommendation.</p> <p>R3's electronic medical record (EMR) lacked evidence R3 had been given information or offered the newer recommended PCV15 or PCV20 vaccination.</p> <p>R13's admission Face Sheet dated 3/2/23, identified R13's age of 91 years. Diagnoses included Alzheimer's disease, diabetes, and kidney failure.</p> <p>R13's MIIIC report dated 3/1/23, identified R13's immunizations. R13 received the PPSV23 on 5/11/07, and PCV13 on 8/29/17. R13's immunization record lacked evidence any other pneumococcal vaccinations, including the newer recommended PCV15 or PCV20 had been offered in conjunction with their providers recommendation.</p> <p>R13's EMR lacked evidence R13 had been given information or offered the newer recommended PCV15 or PCV20.</p> <p>R70's admission Face Sheet dated 12/21/23, identified R70's age 74. Diagnoses included Stage four pressure ulcer, atrial fibrillation, kidney disease, heart failure and kidney disease.</p> <p>R70's MIIIC report dated 7/31/24, identified R70's immunizations. R70 received the PPSV23 on 4/16/07, 10/31/07, and 8/30/17 and the PCV13 on 10/14/15. R70's immunization record lacked</p> | F 883                                                                      | <p>After identifying at risk residents, audits will be conducted on admission and quarterly at care conferences to identify residents that are eligible for a pneumococcal vaccine on an ongoing basis.</p> <p>PneumoRecs VaxAdvisor app has been downloaded to the facility phone for all nurse managers to be able to reference in determining if a resident is eligible for a pneumococcal vaccine.</p> <p>The nurse managers and social services designee will be educated on the new process of monitor of pneumococcal eligibility with care conferences and on the use of the PneumoRecs VaxAdvisor app to determine eligibility.</p> <p>Consent forms will identify the VIS provided to the resident or resident representative when offering the pneumococcal vaccine.</p> <p>To ensure compliance; an audit on admission and quarterly reviews will be conducted by the DON and/or designee on 5 residents per month x 4 months as needed thereafter; results will be reviewed by quality council for monitoring and assured compliance. The DON is responsible for compliance. Facility will achieve substantial compliance September 2, 2024.</p> |  |                                                                        |



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

PRINTED: 08/26/2024  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245484</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                           |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>07/31/2024</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>VILLA ST VINCENT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>516 WALSH STREET</b><br><b>CROOKSTON, MN 56716</b> |                                                                                                                          |                                                                        |                            |
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| F 883                                                       | <p>Continued From page 34</p> <p>evidence any other pneumococcal vaccinations, including the newer recommended PCV15 or PCV20 had been offered in conjunction with their providers recommendation.</p> <p>R70's EMR lacked evidence R39 had been given information or offered the newer recommended PCV15 or PCV20 vaccination.</p> <p>R72's admission Face Sheet dated 7/18/23, identified R72's age 90. Diagnoses included dementia, polymyalgia rheumatica, obesity, heart disease and cerebral infarction (stroke).</p> <p>R72's MIIIC report dated 7/31/24, identified R72's immunizations. R72 received the PPSV23 on 12/18/13, and the PCV13 on 12/18/14. R72's immunization record lacked evidence any other pneumococcal vaccinations, including the newer recommended PCV15 or PCV20 had been offered in conjunction with their providers recommendation.</p> <p>R72's EMR lacked evidence R39 had been given information or offered the newer recommended PCV15 or PCV20 vaccination.</p> <p>When interviewed on 7/31/24, at 1:36 p.m. registered nurse (RN)-B stated she was aware the residents were due for the updated pneumonia vaccinations but had not yet offered it to them. RN-B had R3, R13, R70 and R72 on her list to offer the new PCV20 vaccine but had not gotten around to offering it to them yet. RN-B had recently gotten back in to the position of infection preventionist and was trying to get a number of things caught up, including offering the PCV15 or PCV20 vaccination to residents.</p> |                                                                            |  | F 883                                                                                          |                                                                                                                          |                                                                        |                            |



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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| F 883                                                       | <p>Continued From page 35</p> <p>During interview on 7/31/24, at 2:59 p.m. the director of nursing (DON) stated she was not aware the PCV20/PCV15 was not being offered to residents and it should have been offered.</p> <p>The Centers for Disease Control (CDC) Pneumococcal Vaccination: Summary of Who and When to Vaccinate dated 9/22/23, identified for adults 65 years or older with immunocompromising conditions, the PCV15 or PCV20 should be given at least five years after the last pneumococcal vaccine.</p> <p>The facility policy Pneumococcal Vaccines for Residents dated 3/18/22, identified the facility would provide education and administration of the PPSV23 and PCV13 to the residents of the facility according to Center for Disease Control (CDC) recommendations. The policy identified the CDC recommended PCV15 or PCV20 to adults who had never received PCV13 if they were 65 years or older with certain chronic medical conditions. The facility had failed to update their policy to reflect the new CDC recommendations.</p> | F 883                                                                      |                                                                                                                          |                            |                                                                        |





*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
August 9, 2024

Administrator  
Villa St Vincent  
516 Walsh Street  
Crookston, MN 56716

Re: State Nursing Home Licensing Orders  
Event ID: U7SL11

Dear Administrator:

The above facility was surveyed on July 29, 2024 through July 31, 2024 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](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:

Jen Bahr, RN, Regional Operations Supervisor  
Bemidji District Office  
Licensing and Certification Program  
Health Regulation Division  
Minnesota Department of Health  
705 5<sup>th</sup> Street NW, Suite A  
Bemidji, Minnesota 56601-2933  
Email: [Jennifer.bahr@state.mn.us](mailto:Jennifer.bahr@state.mn.us)  
Office: (218) 308-2104

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

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
Health Regulation Division  
Telephone: (651) 201-4112  
Email: [Kamala.Fiske-Downing@state.mn.us](mailto:Kamala.Fiske-Downing@state.mn.us)



Minnesota Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>VILLA ST VINCENT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>516 WALSH STREET</b><br><b>CROOKSTON, MN 56716</b>                           |  |                                                                    |
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| 2 000                                                       | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS:<br/>On 7/29/24 through 7/31/24, 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</p> | 2 000                                                                     |                                                                                                                          |  |                                                                    |

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

08/19/24



Minnesota Department of Health

|                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                  |                                                                                                                          |  |                                                   |
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| 2 000                                                | <p>Continued From page 1</p> <p>identify the date when they will be completed.</p> <p>The following complaints were reviewed:<br/>H54846204C (MN00104665), H54846205C (MN00102744), H54846206C (MN00104352), H54846305C (MN00105196) and H54846207C (MN00102137) with no orders issued.</p> <p>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.</p> <p>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin<br/><a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html</a> 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.</p> | 2 000                                                                            |                                                                                                                          |  |                                                   |



Minnesota Department of Health

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| 2 545                                                       | <p>MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency</p> <p>Subp. 3. Frequency. Comprehensive resident assessments must be conducted:</p> <p>    A. within 14 days after the date of admission;</p> <p>    B. within 14 days after a significant change in the resident's physical or mental condition; and</p> <p>    C. at least once every 12 months.</p> <p>This MN Requirement is not met as evidenced by:</p> <p>Based on interview and document review, the facility failed to ensure a significant change in status Minimum Data Set (MDS) was completed as directed for 2 of 2 residents (R64, R296) reviewed for significant change in status.</p> <p>Findings include:</p> <p>R64's quarterly Minimum Data Set (MDS) dated 1/27/24, identified R64 had moderate cognitive impairment and required supervision or touch assistance with toileting hygiene, bed mobility, transfers and ambulation. Diagnoses included dementia, Alzheimer's, repeated falls, heart disease and diabetes.</p> | 2 545                                                                                          | corrected                                                                                                                |  | 9/2/24                                                             |



Minnesota Department of Health

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| 2 545                                                | <p>Continued From page 3</p> <p>R64's discharge assessment MDS dated 3/28/24, identified R64 required substantial to maximum assist with toileting hygiene, and bed mobility, partial to moderate assist with transfers and ambulation was not attempted.</p> <p>R64's quarterly MDS dated 4/26/24, identified R54 required substantial to maximum assist with toileting hygiene and bed mobility and was dependent on staff with transfers. R64 was unable to ambulate.</p> <p>R64's quarterly MDS dated 7/24/24, identified R64 was dependent with toileting hygiene, required substantial to maximum assist with bed mobility and was dependent on staff with transfers. R64 was unable to ambulate.</p> <p>When interviewed on 7/31/24, at 10:23 a.m. registered nurse (RN)-C stated she completed R64's MDS when it was due. Licensed practical nurse (LPN)-C notified her when a resident was due for an MDS and also tracked when significant changes needed to be done. RN-C did not track that sort of thing and just followed the list she was provided.</p> <p>During interview on 7/31/24, at 11:22 a.m. LPN-C stated whenever new dependencies were coded a significant change MDS needed to be completed. R64 should have had one done. Therapy had been working with him and so she had not recognized that R64 was no longer ambulating. It was important to complete significant change MDS when changes occur with residents so there was further discussion regarding that resident's care, the care plan was brought up to date and staff were providing care accordingly.</p> | 2 545                                                                            |                                                                                                                          |  |                                                   |



Minnesota Department of Health

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| 2 545                                                | <p>Continued From page 4</p> <p>When interviewed on 7/31/24, at 2:34 p.m. the director of nursing stated she would have expected a significant change MDS be completed for R64 when he was newly coded dependent with transfers and non ambulatory. It was important to complete the significant change MDS so the resident's care plan was update and accurate and staff were providing the care the resident needed.</p> <p>R296's quarterly MDS dated 3/22/24, identified R296 had moderate cognitive impairment and required substantial or maximum assistance with toileting hygiene, dressing, bed mobility and transfers. R296 required partial to moderate assist with ambulation. Diagnoses included dementia, osteoarthritis, anxiety, muscle weakness, kidney disease, heart disease and diabetes.</p> <p>R296's care plan problem with start date 4/23/24, identified a problem with mobility due to R296 was limited with bed mobility, transfers and toileting with goal to receive extensive assistance of one to two people to steady for transfers and toileting and two people to boost up in bed. The newly identified care plan problem with mobility on 4/23/24, indicated the facility was aware of the significant decline with R296's mobility, however, the medical record lacked evidence a significant change assessment had been initiated.</p> <p>R296's Physical Therapy Discharge Summary dated 4/30/24, identified R296 was discharged due to had reached her highest practical level. R296's had participated with therapeutic activities for wheelchair mobility and transfers. Refused to exercise or walk due to back pain with diagnosis of fracture at L1.</p> | 2 545                                                                            |                                                                                                                          |  |                                                   |



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| 2 545                                                | <p>Continued From page 5</p> <p>R296's progress notes 4/1/24 through 5/12/24, identified the following:</p> <p>On 4/1/24, R296 had experienced a fall that resulted in a lumbar fracture.</p> <p>On 4/5/24, physical therapy had evaluated R296 and order received for therapy three times per week.</p> <p>On 5/1/24, R296 was admitted to hospice services.</p> <p>A death in facility MDS tracking record dated 5/12/24, identified R296 expired at the facility under hospice care</p> <p>During interview on 7/31/24, at 11:13 a.m. registered nurse (RN)-C stated she was responsible for completing R296's MDS but was not aware a significant change MDS was needed. LPN-C notified her when MDS were due and if significant changes were needed.</p> <p>When interviewed on 7/31/24, at 11:15 a.m. LPN-C stated she was aware when residents required a significant change at the facility daily interdisciplinary team (IDT) meetings. LPN-C identified a hospice admission would be an automatic reason to complete a significant change MDS, and she had not schedule an MDS assessment. There should have been a significant change MDS assessment completed for R296 with her decline in condition as well as her hospice admission.</p> <p>When interviewed on 7/31/24, at 2:24 p.m. the DON stated she would have expected a significant change MDS assessment to have been completed for R296 related to her decline in</p> | 2 545                                                           |                                                                                                                          |  |                                                   |



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| 2 545                                                       | <p>Continued From page 6</p> <p>mobility as well as her hospice admission. It was important to complete the significant change MDS assessments to identify and capture when a resident has a change for the good or the bad and ensure the staff were providing the care to the resident to meet their needs.</p> <p>The facility's undated Comprehensive Assessments and Care Planning policy, identified the RN coordinator with input from the IDT would determine if it was necessary to complete a significant change MDS. A significant change assessment would be appropriate if there were a consistent pattern of changes with two or more areas of decline or improvement or one area that required extensive care plan revision.</p> <p>SUGGESTED METHOD OF CORRECTION:The DON or designee could educate staff when a significant change in assessment was needed and develop of system for tracking and completing the significant change MDS. The DON or designee could audit MDS assessments to ensure compliance and bring the results to their quality meeting.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p> | 2 545                                                                                    |                                                                                                                          |  |                                                                    |
| 21390                                                       | <p>MN Rule 4658.0800 Subp. 4 A-I Infection Control</p> <p>Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following:</p> <p>A. surveillance based on systematic data collection to identify nosocomial infections in residents;</p> <p>B. a system for detection, investigation, and control of outbreaks of infectious diseases;</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 21390                                                                                    |                                                                                                                          |  | 9/2/24                                                             |



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| 21390                                                | <p>Continued From page 7</p> <p>C. isolation and precautions systems to reduce risk of transmission of infectious agents;<br/>D. in-service education in infection prevention and control;<br/>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;<br/>F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815;<br/>G. a system for reviewing antibiotic use;<br/>H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and<br/>I. methods for maintaining awareness of current standards of practice in infection control.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview and document review the facility failed to ensure enhanced barrier precautions (EBP) were utilized with residents with a catheter for 2 of 2 residents (R1, R69) reviewed for catheters.</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS) dated 5/15/24, identified R1 had severe cognitive impairment and had an indwelling catheter. R1's undated Facesheet identified diagnoses of chronic kidney disease and urinary retention.</p> <p>R1's care plan dated 6/11/24, identified R1 had a catheter and included interventions to manage</p> | 21390                                                           | corrected                                                                                                                |                          |                                                   |



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| 21390                                                | <p>Continued From page 8</p> <p>the catheter; however, the care plan failed to identify if R1 was on EBP and when EBP was to be used.</p> <p>On 7/29/24 5:32 p.m. R1 was observed lying in bed and had a catheter leg bag attached to his right leg and was draining yellow urine. The was no personal protective equipment (PPE) cart in or outside R1's room and there was nothing on the door or elsewhere identifying R1 was on EBP.</p> <p>On 7/30/24 at 9:46 a.m., R1 was seated on the bed and nursing assistant (NA)-D was observed emptying the leg bag to the catheter. NA-D was wearing gloves; however, did not have a gown on. NA-D finished emptying the catheter, cleansed the port with alcohol, emptied the urine, removed their gloves and sanitized their hands and exited the room.</p> <p>During interview on 7/30/24 9:48 a.m., NA-D could not state if they were to wear a gown when emptying the catheter for R1 and would have to ask.</p> <p>R69's quarterly MDS 6/20/24, identified R1 had moderate cognitive impairment and had and indwelling catheter. R69's undated Facesheet identified a diagnosis of urethral stricture.</p> <p>R69's care plan dated 5/30/24, identified R69 had a catheter and included interventions to manage the catheter; however, the care plan failed to identify if R69 was on EBP and when EBP was to be used.</p> <p>On 7/29/24 12:52 at p.m. R69 was observed seated in his wheelchair and had a catheter leg bag attached to his right leg and draining yellow. The was no PPE cart in or outside R69's room</p> | 21390                                                           |                                                                                                                          |  |                                                   |



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| 21390                                                | <p>Continued From page 9</p> <p>and there was nothing on the door or elsewhere identifying R69 was on EBP.</p> <p>On 7/30/24 at 10:36 a.m. R69 was not in his room and there continued to no PPE cart in or outside R69's room and there was nothing on the door or elsewhere identifying R69 was on EBP.</p> <p>On 7/30/24 at 11:32 a.m. NA-E was observed placing a PPE cart outside R69's room.</p> <p>During interview on 7/30/24 at 11:32 a.m. NA-E stated she was placing the cart for EBP outside R69's room as R69 was supposed to be on EBP because he had a catheter. There had not been PPE carts for R69 or R1 and none of the staff had been wearing gowns while providing care for the R69 and R1 while in their rooms.</p> <p>During interview on 7/30/24 at 11:36 a.m. registered nurse (RN)-B, who was also the facility infection preventionist, stated her understanding was EBP was more of a suggestion and then all of a sudden it was implemented. Other residents in the facility had EBP however, RN-B could not explain why R1 and R69, who resided on the memory care unit, did not have the EBP implemented. RN-B stated EBP was to be used with any residents that had an external line like a catheter and with chronic wounds.</p> <p>When interviewed in 7/30/24 at 11:40 a.m. stated R1 had a catheter for some time and R69 had got a new indwelling catheter placed a couple weeks ago. RN-B could not identify why EBP were not implemented for R1 and R69.</p> <p>The facility policy Enhanced Barrier Precautions dated 3/28/24, identified EBP was a strategy in nursing homes to decrease the transmission of</p> | 21390                                                           |                                                                                                                          |  |                                                   |



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| 21390                                                | Continued From page 10<br><br>multi drug resistant organisms (MDR)). EBP would be used for residents actively infected or colonized with an MDRO along with those with an indwelling medical device and or chronic wounds requiring a dressing would be required to use EBP. EBP should be used during high contact resident care activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs/toileting, indwelling medical care device including central line/urinary catheter/feeding tube/tracheotomy/ventilator and with any chronic wound care.<br><br>SUGGESTED METHOD OF CORRECTION: The DON or designee could ensure EBP were initiated for all eligible residents, along with a system for staff to identify when EBP should be used and audit staff compliance for appropriate use of PPE and bring the results of the audits to the quality meeting.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21390                                                                            |                                                                                                                          |  |                                                   |
| 21530                                                | MN Rule 4658.1310 A.B.C Drug Regimen Review<br><br>A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change.                                                                                                                                                                                                                                                                                                                                                       | 21530                                                                            |                                                                                                                          |  | 9/2/24                                            |



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| NAME OF PROVIDER OR SUPPLIER<br><br>VILLA ST VINCENT |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>516 WALSH STREET<br>CROOKSTON, MN 56716                                         |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| 21530                                                | <p>Continued From page 11</p> <p>B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician.</p> <p>C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and document review, the facility failed to ensure the provider documented a thorough rationale for continued use of medications for 1 of 5 residents (R64) reviewed for unnecessary medication use.</p> <p>Findings include:</p> <p>R64's undated Active Orders report identified R64 had current physician orders for sertraline (an</p> | 21530                                                           | corrected                                                                                                                |  |                                                   |



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| 21530                                                | <p>Continued From page 12</p> <p>antidepressant medication) 50 milligrams (mg) every morning with start date 10/21/22. A previous order for trazadone (an antidepressant medication) 50 mg one-half tablet every bedtime, had been ordered with start date 10/20/22, and discontinued date 3/26/24.</p> <p>R64's Consultant Pharmacist Recommendation to Physician dated 8/24/23, identified the consulting pharmacist (CP) identified R64 was receiving sertraline 50 mg and trazadone 25 mg every day. R64's medical record lacked evidence of depression symptoms. The CP recommended according to practice guidelines; a trial reduction may be reasonable. R64's primary physician responded, continue antidepressant therapy, a dose reduction was contraindicated and to see progress note below or in chart with no further notation.</p> <p>R64's medical record was reviewed and lacked any other documentation or dictation from R64s provider regarding the justification of continued use of the antidepressant medications.</p> <p>When interviewed on 7/31/24 at 10:23 a.m., registered nurse (RN)-C stated R64's trazadone was stopped in March because a narcotic had been ordered. RN-C would have to talk to R64's primary provider about the need for rationale to deny a gradual dose reduction for his antidepressant medications. RN-C was not aware it was ever brought up again since the pharmacist made the recommendation in August the previous year. When the physician sends back something indicating no changes, she never questioned it. The director of nursing (DON) had a recent meeting with the providers group and the need to address pharmacist recommendations and provide rationale for dosing decisions was</p> | 21530                                                           |                                                                                                                          |  |                                                   |



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| 21530                                                | <p>Continued From page 13</p> <p>brought up to them as it was recognized as a problem for the facility.</p> <p>When interviewed on 7/31/24 at 2:34 p.m., the DON stated usually when CP-E made recommendations that were not properly addressed, he would send follow up recommendations the following month. The facility had been having some struggles with certain providers addressing the pharmacy recommendations. The DON had just met with the providers the previous month and physician response to pharmacy recommendations was discussed. The DON felt the providers had a better understanding of the issues and were now aware of what the facility expectations were.</p> <p>During telephone interview on 7/31/24 at 3:00 p.m., CP-E stated he had made recommendations to taper R64's antidepressant medications in August 2023. CP-E usually brings the issue up every few months when a provider declines a recommendation. R64 had experienced a number of falls and medication changes in March 2024 and so by the time he was going to readdress the issue with the provider again, the antidepressant medications were the least of his worries. CP-E verified the time between his recommendations in August until R64 had change in condition was seven months.</p> <p>On 7/31/24 at 3:27 p.m., a telephone interview was attempted with the medical director (MD)-F with no answer. A message was left for return call.</p> <p>On 8/1/24 at 3:15 p.m., MD-F returned call. MD-F stated he was aware of the issues with some of the primary providers failing to respond</p> | 21530                                                           |                                                                                                                          |  |                                                   |



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| 21530                                                | Continued From page 14<br><br>adequately to pharmacist recommendations. It had been discussed during the last quality assurance performance improvement (QAPI) meeting and the pharmacist had provided a list of the providers who frequently did not address medications recommendations. MD-F was planning to set up a meeting with the providers to find out what the issues were and why they were not responding appropriately to the pharmacist recommendations.<br><br>SUGGESTED METHOD OF CORRECTION: The DON or designee could ensure the pharmacist and/or facility were following up on resident medication recommendations to the primary provider and ensure gradual dose reductions were attempted or rationale of why they were not.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21530                                                           |                                                                                                                          |  |                                                   |
| 21535                                                | MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General<br><br>Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:<br>A. in excessive dose, including duplicate drug therapy;<br>B. for excessive duration;<br>C. without adequate indications for its use; or<br>D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued.<br>In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section                                                                                                                                                  | 21535                                                           |                                                                                                                          |  | 9/2/24                                            |



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| 21535                                                | <p>Continued From page 15</p> <p>483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview and document review, the facility failed to ensure there was a process to ensure a gradual dose reduction (GDR) or adequate medical justification documented for psychotropic medications was implemented for for 1 of 5 residents (R64) reviewed for unnecessary medications.</p> <p>Findings include:</p> <p>R64's quarterly Minimum Data Set (MDS) dated 7/24/24, identified R64 had moderate cognitive impairment and R64's mood interview did not identify syptoms of depression. R64 received antidepressant medication on a daily basis.</p> <p>R64's undated Active Orders report identified R64 had current physician orders for sertraline (an antidepressant medication) 50 milligrams (mg) every morning with start date 10/21/22. A previous order for trazodone (an antidepressant medication) 50 mg one-half tablet every bedtime, had been ordered with start date 10/20/22, and discontinue date 3/26/24.</p> <p>R64's Consultant Pharmacist Recommendation to Physician dated 8/24/23, identified the</p> | 21535                                                                            | corrected                                                                                                                |  |                                                   |



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| 21535                                                | <p>Continued From page 16</p> <p>consulting pharmacist (CP) identified R64 was receiving sertraline 50 mg and trazadone 25 mg every day. R64's medical record lacked evidence of depression symptoms. The CP recommended according to practice guidelines; a trial reduction may be reasonable. R64's primary physician responded, continue antidepressant therapy, a dose reduction was contraindicated and to see progress note below or in chart with no further notation.</p> <p>R64's medical record was reviewed and lacked any other documentation or dictation from R64s provider regarding the justification of continued use of the antidepressant medications.</p> <p>On 7/30/24, at 9:42 a.m. R64 was lying in bed watching television. R64 was fully dressed and groomed and stated he had already been up for his breakfast and now returned to bed. R64 was pleasant and smiling.</p> <p>When interviewed on 7/31/24 at 10:23 a.m., registered nurse (RN)-C stated R64's trazadone was stopped in March because a narcotic had been ordered. RN-C would have to talk to R64's primary provider about the need for rationale to deny a gradual dose reduction for his antidepressant medications. RN-C was not aware it was ever brought up again since the pharmacist made the recommendation in August the previous year. When the physician sends back something indicating no changes, she never questioned it. The director of nursing (DON) had a recent meeting with the providers group and the need to address pharmacist recommendations and provide rationale for dosing decisions was brought up to them as it was recognized as a problem for the facility. RN-C did not identify what the nursing process was to address GDR's or a</p> | 21535                                                           |                                                                                                                          |  |                                                   |



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| 21535                                                       | <p>Continued From page 17</p> <p>rationale from the provider.</p> <p>When interviewed on 7/31/24 at 2:34 p.m., the DON stated usually when CP-E made recommendations that were not properly addressed, he would send follow up recommendations the following month. The facility had been having some struggles with certain providers addressing the pharmacy recommendations. The DON had just met with the providers the previous month and physician response to pharmacy recommendations was discussed. The DON felt the providers had a better understanding of the issues and were now aware of what the facility expectations were. DON did not identify what the nursing process was to address GDR's or a rationale from the provider outside of the CP-E's recommendations.</p> <p>A policy for psychotropic medication dose reduction was requested, however, none was received.</p> <p>SUGGESTED METHOD OF CORRECTION: The DON or designee could ensure all residents who received psychotropic medications had gradual dose reductions attempted or provided rationale of why it was contraindicated. The DON or designee could perform monthly audits to ensure facility compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p> | 21535                                                                  |                                                                                                                          |  |                                                                 |
| 21610                                                       | <p>MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage</p> <p>Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 21610                                                                  |                                                                                                                          |  | 9/2/24                                                          |



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| 21610                                                       | <p>Continued From page 18</p> <p>under proper temperature controls, and permit only authorized nursing personnel to have access to the keys.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview and document review the facility failed to ensure medications were safely and securely stored for 1 of 1 resident (R70) reviewed for medication storage.</p> <p>Findings include:</p> <p>R70's quarterly Minimum Data Set (MDS) dated 6/22/24, identified R70 had moderate cognition and required assistance with activities of daily living (ADL)'s. R70's diagnoses included stage IV pressure ulcers of the sacral region, right hip and left hip, and type 2 diabetes.</p> <p>During observation on 7/30/24 at 4:18 p.m., Vashe (Dakin's) solution wound cleanser and Nystatin powder (an antifungal medication used to treat infections) were sitting on the dresser in R70's room.</p> <p>R70's undated physicians order report included Dakin's 0.125% wound cleansing solution. The report failed to include orders for Nystatin powder.</p> <p>R70's medical record lacked assessment and care plan to have medications stored at the bedside.</p> <p>During interview on 7/30/24 at 4:18 p.m., R70 stated the medications were always left on the dresser in her room and the nurses use the medications for her dressing change. R70 was uncertain of the medication's names.</p> | 21610                                                                  | corrected                                                                                                                |  |                                                                 |



Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>00815</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>07/31/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>VILLA ST VINCENT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>516 WALSH STREET</b><br><b>CROOKSTON, MN 56716</b>                           |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| 21610                                                       | <p>Continued From page 19</p> <p>On 7/31/24 at 10:05 a.m., licensed practical nurse (LPN)-A stated R70 had a current order for wound cleanser solution, however, there were no current orders for Nystatin powder. Further, LPN-A stated the medications should not be left in R70's room in an unsecured area.</p> <p>On 7/31/24 at 10:32 a.m., registered nurse (RN)-A stated she was aware of the unsecured medications left in R70's room. RN-A stated medications left in a resident's room should be in a secured and safe place that is out of reach to residents.</p> <p>The Self-Administration of Medications policy dated 2/19, identified medications self-administered medications must be stored in a safe and secure place, which is not accessible y other residents. If safe storage is not possible, the medications will be stored on a central medication cart or in the medication room.</p> <p>SUGGESTED METHOD OF CORRECTION:The DON or designee could educate licensed staff on appropriate storage of all prescribed medications and creams and perform audits to ensure all prescribed medications were stored appropriately.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p> | 21610                                                                     |                                                                                                                          |  |                                                                    |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>VILLA ST VINCENT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>516 WALSH STREET</b><br><b>CROOKSTON, MN 56716</b>                           |                            |                                                        |
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| K 000                                                       | <p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 07/30/2024. At the time of this survey, Villa St. Vincent was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.</p> <p>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.</p> <p>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:</p> <p>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.</p> | K 000                                                                      |                                                                                                                          |                            |                                                        |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
  
Electronically Signed

TITLE

(X6) DATE  
  
08/16/2024

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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| K 000                                                       | <p>Continued From page 1</p> <p>Healthcare Fire Inspections<br/>State Fire Marshal Division<br/>445 Minnesota St., Suite 145<br/>St. Paul, MN 55101-5145, OR</p> <p>By email to:<br/>FM.HC.Inspections@state.mn.us</p> <p>THE PLAN OF CORRECTION FOR EACH<br/>DEFICIENCY MUST INCLUDE ALL OF THE<br/>FOLLOWING INFORMATION:</p> <ol style="list-style-type: none"><li>1. A detailed description of the corrective action<br/>taken or planned to correct the deficiency.</li><li>2. Address the measures that will be put in place<br/>to ensure the deficiency does not reoccur.</li><li>3. Indicate how the facility plans to monitor future<br/>performance to ensure solutions are sustained.</li><li>4. Identify who is responsible for the corrective<br/>actions and monitoring of compliance.</li><li>5. The actual or proposed date for completion of<br/>the remedy.</li></ol> <p>Villa St Vincent was built at 4 different times. The<br/>1975 (original) building is 1-story, does not have a<br/>basement, was determined to be Type II(000)<br/>construction and is separated from the multi-story<br/>senior apartment building (1950 building) with at<br/>least a 3-hour fire barrier. In 1988 a chapel addition<br/>was added to the south west of the original<br/>building, is 1-story, no basement, Type V (111)<br/>construction and separated with a 2-hour fire</p> | K 000                                                                      |                                                                                                                          |                            |                                                        |



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| K 000                                                       | Continued From page 2<br><br>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.<br><br>The facility is protected with a complete automatic sprinkler system and also has a fire alarm system with corridor smoke detection and smoke detectors in all common areas that is monitored for automatic fire department notification.<br><br>The facility has a capacity of 104 beds and had a census of 90 at the time of the survey. | K 000                                                                      |                                                                                                                               |                            |                                                        |
| K 281<br>SS=D                                               | The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:<br>Illumination of Means of Egress<br>CFR(s): NFPA 101<br><br>Illumination of Means of Egress<br>Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview the facility failed to provide the level of lighting as required by the Life Safety Code, (NFPA 101) 2012                                                                                                                                                                                                                                                                                                  | K 281                                                                      | All light bulbs were replaced and verified to be working. A task has been added into our TELS Building Services App to ensure | 9/2/24                     |                                                        |



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| K 281                                                       | Continued From page 3<br><br>edition section 7.8.1.4. This deficient finding could have an isolated impact on the residents within the facility.<br><br>Findings include:<br><br>On 07/30/2024 between 8:00am and 12:00pm, it was revealed by observation that the exterior lights for A2 Exit (by room 158) of the exit discharges had only one bulb for illumination. Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2.2 lux) in any designated area.<br><br>An interview with the Director of Plant Operations verified this deficient finding at the time of discovery.                                                                                      | K 281                                                                      | they are periodically checked. Any lights that are burnt out will be reported to the maintenance department. Education will be provided by 08/30/2024. |                            |                                                        |
| K 321<br>SS=F                                               | Hazardous Areas - Enclosure<br>CFR(s): NFPA 101<br><br>Hazardous Areas - Enclosure<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9 | K 321                                                                      |                                                                                                                                                        | 9/2/24                     |                                                        |



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| K 321                                                       | Continued From page 4<br><br>Area Automatic Sprinkler<br>Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms<br>(exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces<br>(over 50 square feet)<br>g. Laboratories (if classified as Severe<br>Hazard - see K322)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the<br>facility failed to maintain their smoke barrier per<br>NFPA 101 (2012 edition), Life Safety Code,<br>sections 19.3.7.3, 8.5.6.5 and 8.5.6.2. These<br>deficient findings could have a widespread impact<br>on the residents within the facility.<br><br>Findings include:<br><br>On 07/30/2024 between 8:00am and 12:00pm, it<br>was revealed by observation that the back doors<br>leading out of OT did not close properly when<br>tested.<br><br>An interview with the Director of Plant Operations<br>verified this deficient finding at the time of<br>discovery. | K 321                                                                      | The back door to OT/PT (Going towards<br>the Chapel) were adjusted by Stanley<br>Access Technologies. The one side closes<br>first before the other side, this allows the<br>doors to close properly. I met with the<br>OT/PT staff and made them aware of this.<br>This door has been be added onto our Fire<br>Door inspection so it is checked annually. |                            |                                                        |
| K 324<br>SS=D                                               | Cooking Facilities<br>CFR(s): NFPA 101<br><br>Cooking Facilities<br>Cooking equipment is protected in accordance<br>with NFPA 96, Standard for Ventilation Control and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | K 324                                                                      |                                                                                                                                                                                                                                                                                                                                                             | 9/2/24                     |                                                        |



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| K 324                                                       | <p>Continued From page 5</p> <p>Fire Protection of Commercial Cooking Operations, unless:</p> <ul style="list-style-type: none"><li>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2</li><li>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or</li><li>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.</li></ul> <p>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.</p> <p>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on documentation review and staff interview, the facility failed to test and inspect the kitchen hood ventilation and fire suppression system per NFPA 101 (2012 edition), Life Safety Code, section 9.2.3 and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section 11.2.1. This deficient finding could have an isolated impact on the residents within the facility.</p> <p>Findings Include:</p> <p>On 07/30/2024 between 8:00am and 12:00pm, it was revealed by a review of available</p> | K 324                                                                      | <p>Our Kitchen Systems Inspection is done by Summit Fire Protection. Our Ansul system was inspected on 3/23/2023, 8/17/2023, and 2/27/2024 by Shelby Williams, a technician for Summit Fire Protection. Further, our Kitchen Hood System was cleaned on 2/16/2023, 9/27/2023, and 2/21/2024 by Hood Cleaners Company located in Moorhead, MN. A high priority work order has been generated by Summit Fire Protection to conduct the next inspection. The same is true for the Hood Cleaning Company, both companies are scheduled on a 6 month</p> |                            |                                                        |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>VILLA ST VINCENT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>516 WALSH STREET</b><br><b>CROOKSTON, MN 56716</b>                           |                            |                                                        |
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| K 324                                                       | Continued From page 6<br><br>documentation that inspection documentation for the kitchen hood ventilation and fire suppression system was not available. The facility could not provide completed test/inspection documentation for the semi-annual kitchen hood suppression system inspections for the last 12 months.<br><br>An interview with the Director of Plant Operations verified this deficient finding at the time of discovery.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | K 324                                                                      | rotation.                                                                                                                |                            |                                                        |
| K 363<br>SS=D                                               | Corridor - Doors<br>CFR(s): NFPA 101<br><br>Corridor - Doors<br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames | K 363                                                                      |                                                                                                                          | 9/2/24                     |                                                        |



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| K 363                                                       | Continued From page 7<br><br>shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility.<br><br>Findings include:<br><br>On 07/30/2024 between 8:00am and 12:00pm, it was revealed by observation that the Clean Linen Storage Room did not close and latch.<br><br>An interview with the Director of Plant Operations verified this deficient finding at the time of discovery. | K 363                                                                      | The clean linen storage room door did not close properly. We have purchased new key pad locks that will arrive 8/21/2024 and will be replaced at that time. We also added these doors onto our monthly checks and into the task in out TELS Building Services application. |                            |                                                        |
| K 372<br>SS=F                                               | Subdivision of Building Spaces - Smoke Barrie<br>CFR(s): NFPA 101<br><br>Subdivision of Building Spaces - Smoke Barrier Construction<br>2012 EXISTING<br>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | K 372                                                                      |                                                                                                                                                                                                                                                                            | 9/2/24                     |                                                        |



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| K 372                                                       | Continued From page 8<br><br>dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.<br>19.3.7.3, 8.6.7.1(1)<br>Describe any mechanical smoke control system in REMARKS.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 07/30/2024 between 8:00am and 12:00pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors leading to Justice Lane and Memory Care Main Entrance.<br><br>An interview with the Director of Plant Operations verified this deficient finding at the time of discovery. | K 372                                                                      | Penetrations in ceiling by Justice Lane and Memory Care. These were sealed with appropriate fire rated caulking on the day of inspection (07/30/2024). Moving forward, the Maintenance Supervisor will meet with any contract doing work here and verify that they do in fact seal any penetrations they create. I have provided training to the Maintenance Technician□s and Maintenance Volunteer on 8/15/2024. If we have a contractor or if we run cable in the ceiling, the Maintenance Department will verify the appropriate caulking was used. |                            |                                                        |
| K 521<br>SS=F                                               | HVAC<br>CFR(s): NFPA 101<br><br>HVAC<br>Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.<br>18.5.2.1, 19.5.2.1, 9.2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | K 521                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 9/2/24                     |                                                        |



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| K 521                                                       | Continued From page 9<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5. 11, and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 07/30/2024 between 8:00am and 12:00pm, it was revealed by a review of available documentation that the facility could not provide a fire damper inspection report.<br><br>An interview with the Director of Plant Operations verified this deficient finding at the time of discovery. | K 521                                                                      | Fire Damper Map. I verified with Johnson Controls Inc. Technician that the inspections were completed and a map was created of the Fire Damper Locations. This map is save with the inspection form and is available in the Maintenance shop. |                            |                                                        |
| K 753<br>SS=D                                               | Combustible Decorations<br>CFR(s): NFPA 101<br><br>Combustible Decorations<br>Combustible decorations shall be prohibited unless one of the following is met: <ul style="list-style-type: none"><li>o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product.</li><li>o Decorations meet NFPA 701.</li><li>o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289.</li><li>o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with</li></ul>                                                                                                                                                                                                      | K 753                                                                      |                                                                                                                                                                                                                                               | 9/2/24                     |                                                        |



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| K 753                                                       | Continued From page 10<br>18.7.5.6(4) or 19.7.5.6(4).<br>o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present.<br>19.7.5.6<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation or a review of available documentation and staff interview, the facility failed to prohibit combustible decorations per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.5.6 and 19.7.5.6 (4). These deficient findings could have an isolated on the residents within the facility.<br><br>Findings include:<br><br>On 07/30/2024 between 8:00am and 12:00pm, it was revealed by observation that a candle was located on a wooden shelf in the common area across from office 162.<br><br>An interview with the Director of Plant Operations verified this deficient finding at the time of discovery. | K 753                                                                      | All candles will have the wicks removed or the candles completely removed.<br>Education will be provided by 08/30/2024.  |                            |                                                        |
| K 761<br>SS=E                                               | Maintenance, Inspection & Testing - Doors<br>CFR(s): NFPA 101<br><br>Maintenance, Inspection & Testing - Doors<br>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.<br>Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.<br>Individuals performing the door inspections and testing possess knowledge, training or experience                                                                                                                                                                                                                                                                                                                                                                      | K 761                                                                      |                                                                                                                          | 9/5/24                     |                                                        |



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| K 761                                                       | <p>Continued From page 11</p> <p>that demonstrates ability.</p> <p>Written records of inspection and testing are maintained and are available for review.</p> <p>19.7.6, 8.3.3.1 (LSC)</p> <p>5.2, 5.2.3 (2010 NFPA 80)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>1) Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a patterned impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 07/30/2024 between 8:00am and 12:00pm, it was revealed by review of available documentation the required annual door inspection documentation was not available at the time of the survey.</p> <p>2) Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 07/30/2024 between 8:00am and 12:00pm, it was revealed by observation that the following fire doors and/or fire door frames were missing door rating tags.</p> | K 761                                                                      | <p>LSS will be onsite on 09/04/2024 to complete labeling of the fire door frames. Education was provided to the maintenance staff to make certain these tags are legible and in place on the doors as well as the door frames.</p> |                            |                                                        |



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| K 761                                                       | Continued From page 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | K 761                                                                      |                                                                                                                                                                                                        |                            |                                                        |
| K 912<br>SS=F                                               | <p>1) Fire doors leading to Station 240 Nurses station<br/>2) Fire doors leading to Station 230 Nurses station</p> <p>An interview with the Director of Plant Operations verified this deficient finding at the time of discovery.</p> <p>Electrical Systems - Receptacles<br/>CFR(s): NFPA 101</p> <p>Electrical Systems - Receptacles<br/>Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover.<br/>If used in patient care room, ground-fault circuit interrupters (GFCI) are listed.<br/>6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99)<br/>This REQUIREMENT is not met as evidenced by:<br/>Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 07/30/2024 between 8:00am and 12:00pm, it was revealed by review of available documentation the required annual receptacle inspection documentation was not available at the time of the survey.</p> | K 912                                                                      | <p>Outlet Testing will be conducted and records will be kept by the maintenance supervisor. Both hard copy and electronically saved. An Annual Task was created in our TELS Building Services App.</p> | 9/2/24                     |                                                        |



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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>245484</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>02 - 1975 EAST BUILDING</b><br><br>B. WING _____                            |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/30/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>VILLA ST VINCENT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>516 WALSH STREET</b><br><b>CROOKSTON, MN 56716</b>                           |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |                                                        |
| K 912                                                       | Continued From page 13                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | K 912                                                                      |                                                                                                                          |                            |                                                        |
| K 918<br>SS=F                                               | <p>An interview with the Director of Plant Operations verified this deficient finding at the time of discovery.</p> <p>Electrical Systems - Essential Electric Syste<br/>CFR(s): NFPA 101</p> <p>Electrical Systems - Essential Electric System<br/>Maintenance and Testing</p> <p>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel.</p> <p>Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new</p> | K 918                                                                      |                                                                                                                          | 9/2/24                     |                                                        |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>VILLA ST VINCENT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>516 WALSH STREET</b><br><b>CROOKSTON, MN 56716</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                            |                                                        |
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| K 918                                                       | Continued From page 14<br>installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of available documentation and staff interview, the facility failed to install and maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.1.1.16.2 and 6.4.1.1.17, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.4.9, 8.4.9.1, 8.4.9.2 and 8.4.9.5.1. These deficient findings could have a widespread impact on the residents within the facility.<br><br>Findings include:<br><br>On 07/30/2024 between 8:00am and 12:00pm, it was revealed by a review of available documentation of the emergency generator maintenance and testing that the facility could not provide documentation that a 36 month four (4) hour load bank test had been performed.<br><br>An interview with the Director of Plant Operations verified this deficient finding at the time of discovery. | K 918                                                                      | We have a signed contract with Ziegler Power Systems to conduct our; Maintenance, Preventative Maintenance and Inspections on our generators on a; Quarterly, Semi Annually and Annual basis. They also conducted full load bank (4-hour) tests to meet the requirement and be compliant. We have went over the formula to verify that we are running at, at least a 30% capacity. Our full load amps are 528 amps and 226 amps. Our generators run at 210 Amps which is well above the 162 Amps and 68 Amps needed to meet the 30% criteria. This is based on the manufactures guidelines and the technician's instruction. The Maintenance Supervisor has entered this task into our Direct Supply TELS App so it is scheduled on a re-occurring basis. |                            |                                                        |
| K 920<br>SS=D                                               | Electrical Equipment - Power Cords and Extens<br>CFR(s): NFPA 101<br><br>Electrical Equipment - Power Cords and Extension Cords<br>Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | K 920                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 9/2/24                     |                                                        |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>VILLA ST VINCENT</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>516 WALSH STREET</b><br><b>CROOKSTON, MN 56716</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                            |                                                        |
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| K 920                                                       | <p>Continued From page 15</p> <p>the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.</p> <p>10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 07/30/2024 between 8:00am and 12:00pm, it was revealed by observation that there was an electrical appliance (refrigerator) plugged into a power strip in Office 162.</p> <p>An interview with the Director of Plant Operations verified this deficient finding at the time of discovery.</p> | K 920                                                                      | <p>All mini refrigerators and microwaves will be directly plugged into an outlet. Education will be provided by 08/30/2024. The maintenance Supervisor and the Housekeeping Supervisors will make monthly rounds to verify this practice is followed. Staff will also report any rooms that don't meet this requirement so that it can be addressed and education can be provided to staff, residents, and resident's family members. Additionally, a task in our TELS Building Services App will be created to perform and document this inspection</p> |                            |                                                        |