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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: ZPVX
Facility ID: 00815

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

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

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

4. TYPE OF ACTION: 7 (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/08/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **104** (L18)
13.Total Certified Beds **104** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program
Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	104			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Jana Bromenshenkel, HFE NEII 03/10/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 03/10/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/07/2016
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245484

March 10, 2016

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

Dear Ms. Hulst:

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

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

Effective February 15, 2016 the above facility is certified for:

104 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 10, 2016

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

RE: Project Number S5484025

Dear Ms. Hulst:

On January 26, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 13, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On March 8, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 13, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 15, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 13, 2016, effective February 15, 2016 and therefore remedies outlined in our letter to you dated January 26, 2016, will not be imposed.

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

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

Sincerely,

Mark Meath

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

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245484	A. Building B. Wing	3/8/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 02/15/2016	ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 02/15/2016	ID Prefix F0428 Reg. # 483.60(c) LSC	Correction Completed 02/15/2016
ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 02/15/2016	ID Prefix F0465 Reg. # 483.70(h) LSC	Correction Completed 02/15/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) LB/mm	DATE 03/10/2016	SIGNATURE OF SURVEYOR 32601	DATE 03/08/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/13/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

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PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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Facility ID: 00815

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(L1) **245484**

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

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(L3) **VILLA ST VINCENT**
(L4) **516 WALSH STREET**
(L5) **CROOKSTON, MN** (L6) **56716**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/13/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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A. In Compliance With
Program Requirements
Compliance Based On:

____1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	104			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Yvonne Switajewski, HFE NEII 02/08/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 03/02/2016 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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3. Both of the Above :

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06/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
January 26, 2016

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

RE: Project Number S5484025

Dear Ms. Hulst:

On January 13, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 22, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

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

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

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

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 13, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 13, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245484	A. BUILDING ______ B. WING ______	01/13/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure there was coordination of care for 1 of 1 (R153) resident reviewed for hospice services. Findings include: R153's Resident Admission Record dated	F 309	Resident #153 is being serviced under Hospice. The Hospice Care Plan has been requested, and recieved, and the Unit Manager on that Wing has coordinated the Care between the Facility staff and the Hospice Provider. Ongoing Coordination will occur as the Hospice Provider visits occur. Plans are coordinated for the services of both the Hospice Provider and the Nursing Home.	2/15/16

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

Electronically Signed — 02/02/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245484	A. BUILDING ______ B. WING ______	01/13/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 1 12/28/15, identified R153's diagnoses as glioblastoma (brain tumor), chronic kidney disease, adult failure to thrive, fatigue, hypertension and palliative care. R153's initial Minimum Data Set (MDS) dated 1/4/16, indicated R153 had severe cognitive impairment, required extensive assist with all activities of daily living and currently received hospice services. On 1/11/16, at 2:45 p.m. R153 was observed in bed, the bed in the low position, call light within reach and appeared comfortable with his eyes closed, no grimacing or moaning noted. On 1/12/16, at 7:06 a.m. R153 was observed in bed, positioned on his right side with pillows propped up behind his back. R153 appeared calm and comfortable. R153's Current Orders dated 12/28/15, indicated R153 had been admitted to the facility with hospice services through Altru Hospice agency. R153's care plan dated 1/8/16, indicated R153's care would be coordinated with the hospice agency. In addition, the facility and the hospice agency were to ensure they were aware of each other's responsibilities when implementing R153's plan of care. However, R153's medical record lacked a care plan from Altru hospice which would have outlined these roles and responsibilities of the facility and the hospice	F 309	The Hospice Provider has submitted a schedule of Visits for this resident. Hospice Care Plan/schedule of visits will be requested from Hospice Services by day 5 of the admission of a resident into Hospice. On 02/03/16 this Hospice Provider met with the Facilty Team, and coordination of expectations was reviewed. The Hospice Provider also did an Inservice that wss focusd on coordination of services, and educating staff on where to locate hospice schedules. All other residents currently being followed by a Hospice Provider will have a review of thier record to assure that the care plan from Hospice is available for coordination of services, and that staff are aware of when Hospice Services will be in the building to provide these services. Unit Managers will audit that Care Plan has arrived from Hospice 5 days after admission into Hospice. Audit will be completed Monthly of residents to assure ongoing compiance of hospice coordination and communication for 6 months, and then randomly thereafter as directed by the QA&A. Responsible party/ DON and RN Unit Managers.	

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agency, the services provided and the schedule for these services.

R153's progress notes (PN) indicated an Altru hospice nurse had visited R153 on 12/31/15, 1/4/16, 1/7/16, and 1/11/16. However, the only visit which indicated a communication of when the next hospice nurse visit would be was on 1/4/16.

On 1/11/16, at 9:00 a.m. the Hospice RN was interviewed regarding the Hospice staff schedule. She stated RNs came on different days and times of the week and the home health aide (HHA) had a schedule of when to see a patient in the facility and wrote the dates and times of the planned visits for the week in the patient's room on their grease board and the dates and times were also written on the board in the charting room.

On 1/12/16, at 8:42 a.m. the facility's licensed social worker (LSW)-A confirmed she coordinated the hospice visits for the facility. LSW-A stated it depended on the resident of how frequently the hospice staff visited. LSW-A confirmed hospice developed a care plan which was always placed in the resident's paper medical record under the tab labeled "hospice." In addition, the hospice agency sent a weekly schedule which identified the care giver which would be coming and the date they would arrive. LSW-A stated this schedule would be posted in the charting room which was adjacent to the nurses' station. LSW-A verified the hospice schedule which was posted in the charting area was for another

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resident and from another hospice agency. LSW-A confirmed there was not a hospice scheduled posted for R153. LSW-A reviewed R153's paper medical record and confirmed the tab behind "hospice" was completely empty and R153's medical record lacked a current hospice care plan. LSW-A verified R153 had been seen by hospice since his admission and confirmed R153's facility care plan indicated the facility would ensure the facility and hospice agency would be aware of the each other's responsibilities. LSW-A confirmed this information was not available to the staff. LSW-A immediately phoned Altru hospice agency and had a care plan faxed to the facility.

On 1/12/16, at 9:27 a.m. registered nurse (RN)-B stated the hospice nursed faxed a weekly schedule to the facility which indicated their upcoming visits. RN-B confirmed R153 was not receiving hospice nursing assistant services. RN-B stated a weekly hospice care plan should be provided from the hospice agency. In addition, the care plan that had been faxed this morning (1/12/16, at 8:58 a.m.) was not accurate. RN-B confirmed the Altru hospice agency had not indicated their visit schedule on the care plan. In addition, the care plan indicated the social worker would visit twice as needed, however, had not indicated when those visits would occur.

On 1/12/16, at 10:26 a.m. Altru hospice LSW-B confirmed the hospice visit schedules were not faxed to the facility. LSW-B stated whoever made the first hospice visit of the week brought the schedule and care plan to the facility. LSW-B verified since R153 had been visited by hospice

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F 309	Continued From page 4 on four previous occasions (12/31/15, 1/4/16, 1/7/16, 1/11/16) there should have been a current care plan in R153's medical record and a posted schedule. LSW-B stated she had attempted to visit R153 around 1/5/16, however, R153 had not been in his room so LSW-B had not completed the visit. LSW-B confirmed she had not charted this attempted visit. LSW-B stated she was scheduled to visit R153 twice a month and when needed. On 1/12/16, at 1:10 p.m. the director of nursing (DON) confirmed the facility worked with two hospice agencies. The DON verified there was a tab in the resident's paper medical record where the hospice care plan should be placed. The DON stated the hospice agencies should send a weekly visit schedule to the facility which identified the care givers who were scheduled to round on the resident. On 1/12/16, at 1:25 p.m. registered nurse care manager (RNCM) from Altru hospice stated the hospice agency had a visit calendar so the hospice registered nurses were aware of their schedule. RNCM stated the hospice agency sent out a weekly care plan and face sheet which included information like the resident's medication list, provider information, visit frequency and interventions along with any updates to this care plan. RNCM confirmed the weekly schedules were hand delivered and the nurse who had visited R153 on 1/11/16, had not delivered R153's care plan, face sheet or the visit schedule. RNCM verified R153 was currently scheduled to receive hospice nursing assistant visits twice a week and a nurse visit twice a week. RNCM	F 309		

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F 309	Continued From page 5 stated the nursing assistant was scheduled to visit R153 today (1/12/16). On 1/12/16, at 1:49 p.m. nursing assistant (NA)-A stated she was familiar with R153's care. NA-A stated she was unsure if or when a hospice nursing assistant provided cares for R153. On 1/12/16, at 2:00 p.m. NA-B stated she thought the hospice nursing assistant came once a week and provided cares for R153. However, she was unaware of the day of the week they were scheduled to come. NA-B stated when R153 was admitted she remembered hearing a hospice nursing assistant was going to come in but she had not heard anything more about their schedule. NA-B verified she had already completed R153's morning cares for the day. Terminal Illness policy dated 6/15, indicated the health care team for the terminally ill resident consisted of (but not limited to) nursing, social services, dietary, pastoral care, physician and hospice as indicated. A policy regarding the coordination of care for hospice services was not provided.	F 309		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or	F 329		2/15/16

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F 329	Continued From page 6 without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide non-pharmacological interventions prior to the administration of as needed anti-anxiety medication for 1 of 5 residents (R39) and failed to obtain the clinical justification for the continued use of gastric reflux medications for 2 of 5 residents (R39, R113) reviewed for unnecessary medications. In addition, the facility failed to follow through on the consulting pharmacist recommendations to obtain clinician progress notes for 2 of 5 residents (R103, R13) who required psychiatric progress notes for medication regimen review.	F 329	It is Villa St. Vincent's policy that all residents will be free of unnecessary medications. A policy, Non-medication interventions before PRN Use, was updated to state that all prn Anti-anxiety medications will have a list of individualized non medication interventions that may be selected for use prior to prn medication administration. The Pharmacist is to provide monitoring of all residents medication regimes. R-39: MAR updated to reflect care planned interventions to ease anxiety and avoid PRN anti-anxiety use whenever possible. All residents on PRN	

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Findings include:

R39 received antianxiety medication without non-pharmacological interventions attempted prior to the administration. R39 also received omeprazole daily without the physician addressing the justification for the the continued use of the medication.

R39's quarterly Minimum Data Set (MDS) dated 10/22/15, indicated R39 was diagnosed with dementia, depression, anxiety, Parkinson's disease and Schizophrenia. The MDS indicated R39 was cognitively impaired and required extensive assistance with all activities of daily living. The MDS also indicated R39 had expressed feelings of being down or depressed, little interest in doing things, trouble falling asleep, feelings of being tired and trouble concentrating on things such as reading the newspaper or watching TV. The assessment indicated R39 had hallucinations and one episode of verbal behavior symptoms directed towards others (e.g.. threatening others, screaming at others, cursing) during the MDs reference period.

R39's Mood Care Area Assessment (CAA) dated 4/23/15, indicated R39 was diagnosed with Parkinson's disease, anxiety and depression. The CAA indicated R39 liked to stay in her room most of the time and at times did not interact with others. The CAA indicated she could be rude and demanding to staff depending on her mood.

R39's Behavior CAA dated 4/23/15, indicated R39 preferred to stay in her room and at times being rude and verbally aggressive with staff and refusing cares.

F 329

anti-anxiety medications were reviewed and all had interventions noted in the MAR. Nurses add the interventions to the special instructions of the MAR. Unit Mangers will audit monthly.
R39 and R113: Both had Omeprazole. Both residents' medications were reviewed by the medical providers as requested by the consulting Pharmacist. It is documented now on the chart. All residents on Omeprazole will have the medical provider address its use every 6 months including an indication and dx for use. Unit Manger and Consulting Pharmacist will audit monthly for updates to occur every 6 months.
R103 and R13: Progress notes indicating the use were received for these residents. Progress Notes will be requested after each visit. Nurse will add under special instructions in EMAR, for possible non-pharmacological interventions before the PRN psychotropic meds administered, document in the progress notes the success of the non-pharmacological intervention, and then give PRN's if indicated.
To be followed by Unit Manager per pharmacy recommendations.
Monthly audit by Unit Manager/Medical Records.

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R39's care plan dated 7/28/15, indicated R39 had a fluctuation in mood and behavior due to history of severe depression and hallucinations. R39 received Alprazolam (antianxiety) for mood.

R39's current Physician's orders and medication administration record (MAR) dated 1/16, included an order for Alprazolam (xanax) 0.25 milligrams (mg) 1/2 tablet for anxiety every 4 hours as needed (PRN).

On 1/11/16, at 2:30 p.m. R39 was observed in her room, in bed.
On 1/12/16, at 6:55 a.m. R39 was observed in bed, sleeping
On 1/13/16, at 8:00 a.m. R39 was observed in bed, sleeping.

Review of R39's MARs revealed the following:

- December 2015, R39 had received 40 doses of PRN Alprazolam per her request for "nerves." R39's medical record did not identify non-pharmacological interventions attempted prior to the administration of the medication.
- January 1-12, 2016, R39 had received 16 doses of PRN Alprazolam due to having behavior issues. R39's medical record did not identify non-pharmacological interventions attempted prior to the administration of the medication.

On 1/13/16, at 1:00 p.m. registered nurse (RN)-C confirmed R39 received a PRN anti-anxiety medication and verified the facility had not identified any type of non-pharmacological interventions to be attempted prior to administration of the medication.

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F 329	Continued From page 9 R39's current physician's order also indicated R39 received omeprazole 20 mg (proton pump inhibitor medication to treat heartburn) which was started one 6/26/12. R39's MAR dated 1/16, indicated R39 received omeprazole 20 mg every morning. However, R39's medical record lacked physician justification for the continued usage of medication. R39's Medication Review form dated 10/22/15, indicated R39 was receiving omeprazole 20 mg daily due to a stomach function disorder diagnosis. R39's pharmacy review notes revealed the following: -On 2/27/15, "Also, omeprazole is ordered for abdominal pain, we need to update on continued need for omeprazole." -On 4/29/15, "Can we get a note on continued need for omeprazole?" -On 6/30/15, "Need a note on omeprazole need." - On 7/27/15, "Need note on omeprazole." indicated the need for continued use of omeprazole for abdominal pain, however, the pharmacist indicated abdominal pain would not be a justified long term indication for omeprazole. On 1/13/16, at 1:15 p.m. RN-C verified R39's physician visited on 8/26/15, 9/28/15, 10/27/15, 11/21/15, 12/30/15, and failed to address R39's continued use of omeprazole nor addressed the pharmacist's recommendations. On 1/12/16, at 3:30 p.m. RN-C stated the physician changed the omeprazole order to PRN and would re-evaluate in a couple of weeks.	F 329		

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R103's medical record lacked mental health physician visit notes as requested by the consulting pharmacist in order to review appropriate medication use.

R103's quarterly MDS dated 10/8/15, indicated R103 was diagnosed with Alzheimer's disease and hypertension. The MDS indicated R103 was cognitively impaired and required extensive assistance with all activities of daily living. The MDS also indicated R103 had little interest in doing things, feeling tired or have little energy and trouble concentrating on things such as reading the newspaper or watching TV. The assessment indicated R103 had behavior symptoms not directed toward staff.

R103's Mood CAA dated 4/9/15, indicated R103 was diagnosed with Alzheimer's disease, had declined cognition and was observed crying and had negative thoughts about self. She does not wish to participate in activities and needs lots of encouragement.

R103's Behavior CAA dated 4/9/16, indicated R103 would fixate on something and yell out repeatedly which was disturbing to the environment. At times was resistive to cares and would yell out during transfers.

R103's pharmacy review notes revealed the following:

-7/22/15, indicated R103 had been seen by mental health physician following a previous visit in March with a follow up to be completed in 6 weeks. However, no progress notes on outcome

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of visit in medical record indicating the follow up visit occurred.
-8/25/15: "See previous."
-9/24/15: Need mental health progress notes in chart.
-10/21/15: Need updated progress note communicating on patients status on her mental health meds. Are they helping? Any side effects?

On 1/13/15, at 9:45 a.m. RN-D verified R103's mental health progress notes were lacking from the medical record. RN-D stated the facility medical records person had been emailing, calling and talking to the mental health physician's office in an attempt to obtain the records.

At that time the medical records person was contacted via telephone who stated R103's May 2015 and Dec. 14, 2015 progress note was not received therefore not in R103's medical record

On 1/13/16, at 10:58 a.m. the pharmacist verified R103's mental health progress notes were lacking from the medical record and stated the notes requested should be in R103's medical record by the next pharmacist monthly visit.

The facility's undated, Non-Pharmacological Interventions policy indicated the facility would attempt non-medication approaches to prevent unnecessary use of anti-psychotic medications. However, the policy did not direct the staff to attempt non-pharmacological interventions prior to the administration of the medications of anti-anxiety medications.

R13's medical record lacked mental health

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F 329	Continued From page 12 physician notes as requested by the consulting pharmacist in order to review for the appropriateness of the medicaiton. R13's quarterly MDS dated 8/11/15, indicated R13 was diagnosed with anxiety, depression and schizophrenia. The MDS also identified R3's medication regime included antipsychotic and antidepressants. R13's care plan updated on 9/30/15, indicated R3 received psychotropic medication due to depression and schizoaffective disorder and was being seen by the psychiatrist. R13's current physician orders indicated R3 had received Abilify (antipsychotic) 10 mg every night at bedtime (HS) since 6/26/15, Navane (antipsychotic) 5 mg at HS since 8/5/15, and Trazadone (antidepressant) at HS since 6/26/15. R13's Psychotropic Medication Use CAA dated 8/11/15, indicated R3's medications were managed by the psychiatrist due to major depression and schizoaffective disorder. The CAA indicated R3 had a decrease in Abilify, Trazadone and Navane on 6/26/15, and another decrease in Navane on 8/5/15, without any change in behavior but less sedated. The CAA noted to see the psychiatrist progress note, however: the mental health notes were not in R13's medical record. A review of the Pharmacist' Problem List indicated the pharmacist requested to review the mental health notes from R3's psychiatrist since 7/23/2015, and the facility had failed to obtain those notes for review.	F 329		

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The resident progress notes and the Referral Forms indicated R3 had been seen by the Psychiatrist on 3/5/15, 6/26/15, 8/5/15, and 9/30/15. These mental health reports were not in the medical record for the facility or pharmacist to review.

R13's pharmacist notes revealed the following:

On 9/23/15, the pharmacist noted, Need recent psychiatrist note in chart. Have medication changes made a difference? Is R3 having more problems with pain or mental health issues with the lower doses, would R3 benefit from switching antidepressants?
On 10/20/15, please see previous recommendations from August and September.
On 11/20/15, need mental health note in chart to review, state requires these to be reviewed and updated.
On 12/28/15, Please see previous notes.

On 1/13/2016, at 10:17 a.m. the DON stated the pharmacist gave her a copy of all the recommendations every month and she would give them to the unit managers for review and to respond to.

The Pharmacist Report of Pharmaceutical Services included the following:
- August of 2015 - Can we get a copy of Psychiatrist note from 8/17/15
- September 2015- Please see previous recommendations. We need a Psychiatrist note in the record
- October 2015- Please see previous recommendations
- November 2015-Please get a mental health note in the chart. The last one we had to review

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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was January 2015
- December 2015-Please see previous recommendations.

On 1/10/16, at 5:00 p.m. a resident interview was completed and R3 was observed to be alert, oriented and pleasant. R3 was observed to be completely dependent on staff for all activities of daily living.

On 1/13/16, at 8:45 a.m. RN-A verified the facility did not have R13's notes from the Psychiatrist visits. RN-A stated R3 had been seen by the Psychiatrist on 3/4/15, 6/26/15, 8/5/15, and 9/30/15, and the last mental health note provided was January 2015. RN-A stated they had attempted to get copies of the notes and for some reason the clinic was not responding. RN-A stated medical records was working on it. RN-A confirmed the pharmacist had been requesting the notes for months in order to determine if R3's medication regime was appropriate.

In addition to requesting the mental health notes, on 11/22/15, the pharmacist questioned if other medication on R3's physician orders could be discontinued. The pharmacist asked if the Loratadine (allergy medication) and Geri-Tussin (cough medicine) could be discontinued as the resident had not used it in over a year. The facility failed to respond or act on that recommendation.

On 1/13/16 at 8:36 a.m. RN-A stated the physician had not discontinued the medication or addressed the recommendation. RN-A stated they could be discontinued because they were both part of the standing orders and could be given if needed.

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On 1/13/2016 at 11:05 a.m. the pharmacist verified the facility did not respond to the above recommendations. The pharmacist stated the mental health notes should be available for review in order to determine minimum effective dose.

R113's omeprazole use was not re-evaluated for the justification of the continued use.

R113's physician order report dated 1/13/16 - 1/13/16, indicated R113 had diagnoses which included dementia, dysphagia (difficulty with swallowing) and gastro-esophageal reflux disease (acid reflux disease). In addition, directed staff to administer omeprazole 20 mg once a morning. The start date for R113's omeprazole, as indicated on this physician order report, was 5/21/15.

R113's medication administration history dated 12/14/15 - 1/13/16, indicated R113 had received a daily dose of omeprazole, except on 12/22/15, and 12/23/15, where it was documented that she had been hospitalized.

R113's monthly Pharmacist's Report Of Pharmaceutical Services For Villa St. Vincent for the last six months (July 2015 - December 2016) lacked identification for the justification for the ongoing use of omeprazole.

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F 329	Continued From page 16 R113's 12/31/15, pharmacy update note lacked identification for the appropriateness for the ongoing use of omeprazole. On 1/13/16, at 9:28 a.m. RN-C verified R113 had received a daily dose of omeprazole since 5/21/15. RN-C stated he was unsure of how long the omeprazole would be continued for R113. RN-C went to retrieve further information he may have had on R113's omeprazole usage. Upon RN-C' s return, RN-C confirmed he had no further information, however he had spoken to the consulting pharmacist who had confirmed R113's omeprazole usage should have been reviewed after six months. On 1/13/16, at 11:05 a.m. the pharmacist confirmed proton pump inhibitors, such as omeprazole, should be evaluated for appropriateness and continuation at the six month mark of use. A policy regarding pharmacy drug regime reviews was not provided.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		2/15/16

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F 428	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consulting pharmacist identified and reported medication irregularities related to the use of as needed anti-anxiety medication without non pharmacological interventions in place for 1 of 1 resident (R39) who received antianxiety medication without non-pharmacological interventions attempted. The facility also failed to ensure consulting pharmacist identified and reported medication irregularities related to the use of anti-reflux medication without re-evaluating the justification for the continued use of the medication for 1 of 2 residents (R113) who received the medication without the pharmacist recommending adequate justification for use. Findings include: R39 received PRN (as needed) anti-anxiety medication and the consulting pharmacist (CP) failed to identify and report the lack of non-pharmacological interventions identified and attempted prior to the administration of the medicaiton. R39's current physician's orders and Medication Administration Record (MAR) dated 1/16, included an order for Alprazolam 0.25 milligrams (mg) 1/2 tablet for anxiety every 4 hours PRN.	F 428	Minnesota Department of Health plan of correction for F329E The facility failed to provide nonpharm interventions prior to administration of prn antianxiety med for R39 and failed to obtain medical justification for use of anti gerd for R39 and R 113. R39..Individualized special instructions listed on emar of resident to guide TMA to consult with nurse regarding need for antianxiety med and to document the behaviors and interventions tried before giving prn and to document follow up to med effectiveness .Education provided to TMA s and nurses. Unit managers to audit as well as QA to audit compliance. Goal for completion and compliance 2-15-16 R39..and R113..The MD will review on rounds the use of proton inhibitors with supporting progress note indicating need . A laminated instruction guide is on all chart carts for MD rounds addressing proton inhibitors as well as addressing to review the pharmacy report in the chart on each round. R3 pharmacy recommendations not followed through&UM educated, UM to audit and the process is to complete all the pharmacy recommendations by months end.The pharmacy report is received monthly from consultant to act on recommendations as written. This will be addressed with each MD by the end of	

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F 428	Continued From page 18 Review of R39's MARs revealed the following: - December 2015, R39 received 40 doses of PRN Alprazolam per her request for "nerves." R39's medical record did not identify non-pharmacological interventions attempted prior to the administration of the medication. - January 1-12, 2016, R39 had received 16 doses of PRN Alprazolam due to having behavioral issues. R39's medical record did not identify non-pharmacological interventions attempted prior to the administration of the medication. R39's medical record lacked any documentation of non-pharmacological interventions to be attempted prior to the administration of the PRN antianxiety medication. Review of R39's Pharmacist Drug Regimen Review forms dated 9/28/15, 10/27/15, 11/21/15, and 12/30/15, did not identify the lack of non-pharmacological interventions identified or implemented by the facility to be used by staff prior to the administration of anti-anxiety medications. On 1/13/16, at 1:15 p.m. registered nurse (RN)-C confirmed R39 received anti-anxiety medications for the treatment of increased mood/restlessness. RN-C verified R39's medical record did not direct staff as to which type of non-pharmacological interventions were to be attempted prior to the administration of the medication nor had the pharmacist identified the lack of non-pharmacological interventions.	F 428	each month and audited per UM. Goal of completion is 2-15-16. Regarding proton inhibitors&.All nurses were educated, process will be audited per UM and QA for compliance.R39 did have hers changed to prn on 1-12-16.MD here for rounds 1-19-16.The omeoprazole continued at prn. It has not been used ..Will update MD today. The MD was contacted on this date regarding the proton inhibitor plan for R113.Goal for compliance 2-15-16. R103 and R 13.and R39&. ***WE do not have a current R13 however we do a R3 on the STAGE 2 SAMPLE RESIDENT LISTING. Pharmacist recommended to obtain clinician progress notes who required psychiatric progress notes for medication regimen review. R103&We have requested 5-29-15 notes, we have the 12-14-15 notes and have requested the progress notes of recent visit 2-3-16. R3 is followed by psychiatry. We do have the 3-4-15, 6-26-15 ,8-5-15 and 9-30-15 progress notes. We have requested the notes of 1-15-16 visit. R39 psych notes, 5-19-08 and 2-3-09..she has not had any pyche visits since that time. She follows with PCP. We have a phone conference mtg set up with NWMHC to review the process of obtaining the progress notes within the month of the visit 2-10-16.. Medical records will be notified prior to all appts with psychiatry and will follow up with request of progress notes of. Medical records to audit. Goal is for compliance by 2-15-16 Pharmacist Monthly note will be in each chart under pharmacy tab for MD to	

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F 428	Continued From page 19 R113's omeprazole (proton pump inhibitor medication to treat heartburn) was not identified by the pharmacist as needing to be re-evaluated for continuation of use. R113's physician order report dated 1/13/16 - 1/13/16, identified R113's diagnoses included dementia, dysphagia (difficulty with swallowing) and gastro-esophageal reflux disease (acid reflux disease). In addition, directed staff to administer omeprazole 20 mg once a morning. The start date for R113's omeprazole as indicated on this physician order report was 5/21/15. R113's medication administration history dated 12/14/15 - 1/13/16, indicated R113 had received a daily dose of omeprazole daily, except on 12/22/15, and 12/23/15, where it was documented that she had been hospitalized. R113's monthly Pharmacist's Report Of Pharmaceutical Services For Villa St. Vincent for the last six months (July 2015 - December 2016) lacked identification for the appropriateness for the ongoing use of omeprazole. R113's 12/31/15, pharmacy updated note located in the progress note section of the medical record, lacked identification for the justification for the ongoing use of omeprazole.	F 428	review on Rounds. UM will review and address concerns monthly as written per pharmacist recommendations. Unit Manager to audit.	

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F 428	Continued From page 20 On 1/13/16, at 9:28 a.m. RN-C verified R113 had received a daily dose of omeprazole since 5/21/15. RN-C stated he was unsure of how long the omeprazole would be continued for R113. RN-C went to retrieve further information he may have had on R113's omeprazole usage. Upon RN-C's return, RN-C confirmed he had no further information, however he had spoken to the CP who had confirmed R113's omeprazole usage should have been reviewed after six months of use. On 1/13/16, at 11:05 a.m. the pharmacist confirmed proton pump inhibitors such as omeprazole should be evaluated for appropriateness and continuation at the six month mark. The pharmacist verified R113's continued usage of omeprazole should have been identified by the CP as this was part of their routine drug regime review. The pharmacist stated he was going to leave a note for the CP to make sure R113's omeprazole was addressed during the upcoming drug regime review. No policy regarding pharmacy drug regime reviews was provided.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431		2/15/16

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F 431	Continued From page 21 reconciled. 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. 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. 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure eye drop medications and nasal spray medications were properly labeled with prescription medication labels and dated when opened for 8 of 8 (R17, R82, R121, R1, R60, R22, R61, R93) residents who received unlabeled eye drop medication and nasal spray medication on the 230/240 wings.	F 431	R17,R82, R121, R1,R60,R61, and R93. Each of these residents, eye, ear medication was removed from the Medication cart. Appropriate medication in question was ordered from the pharmacy with identifying appropriate information: RX#, name, directions and expirationn date. Once packaging is opened,the identifying information above will be kept with the bottle, if it is not	

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F 431	Continued From page 22 Findings include: On 01/13/2016, at 8:56 a.m. the 230 medication cart storage review was conducted with trained medication assistant (TMA)-A. During the review the following was observed were observed in the medication drawer without a prescription label, resident name, nor a date when opened identified. 2 bottles of Xalatan (Latanoprost) ophthalmic drops 0.005% Lumigan 0.01% ophthalmic drops Fluticasone (Flonase) suspension 4 bottles of Artificial tears (dextran 70-hypromellose) drops Timolol maleate 0.05% eye drops Hypotears (polyethyl glycol-polyvinyl) opthalmic drops TMA-A verified the medications were prescribed for R82, R17, R60, R121 and R93. TMA-A confirmed the medication bottles did not have a prescription medication label attached and all of the eye drop bottles were not dated when opened. TMA-A further stated, she was not sure who one of the bottles of the artificial tears were for and would throw it away. TMA-A stated all eye drop and nasal spray medications should be labeled with a prescription medication label and a date when the bottle was opened. TMA-A stated she had training on administering medications safely and confirmed medication labels were to be verified with the medication record for accuracy of medication administration. TMA-A stated she would remove the unlabeled eye drop medication bottles and call pharmacy immediately	F 431	labeled directly on the bottle. (some bottles are too small to get a label with this much information on it), therefore, the box will be kept for the date of opening and appropraite expiration date. All eye, ear, and nose drops will be ordered with RX label for each individual resident. Notice for the medication passers was communicated to these staff as to new guidance/Education on this. TMA and QA to audit.	

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F 431	Continued From page 23 to obtain prescription labels for the eye drops and nasal spray. On 01/13/2016 at 9:16 a.m. the 240 medication cart storage review was conducted with trained medication assistant (TMA)-B. During the review a bottle Xalatan (Latanoprost) 0.005% opthalmic drops and a bottle of Artificial tears 1.4% were observed in the medication cart drawer. TMA-B verified the eye drops were prescribed for R22 and R1. TMA-B verified the bottles did not have an appropriate prescription medication label attached, and both eye drop bottles were not dated when opened. TMA-B stated she had training on administering medications safely and medication labels were to be verified with the medication administration record for accuracy of medication administration. TMA-B stated the medications could easily be administered incorrectly when lacking resident prescription labels. TMA-B stated she would contact pharmacy for proper prescription labels for the medications. On 01/13/2016, at 10:08 a.m. the director of nursing (DON) verified all medications including eye drops should have prescription medication labels on them so staff could accurately dispense medications to the appropriate resident. The DON stated eye drops should be dated indicating when they were opened for proper discarding. On 01/13/2016, at 11:04 a.m. the consulting pharmacist (CP) stated the facility should have made sure all eye drops and nasal spray bottles were labeled appropriately with prescription labels	F 431		

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F 431	Continued From page 24 and dated when opened. The CP stated if the facility utilized a stock medication or if a label came off, staff could always send the medication to the pharmacy for appropriate labeling. The CP stated the facility should have been keeping the eye drop/nasal prescription labeled boxes with the corresponding eye drops/nasal sprays while stored. The facility Medication Labels policy dated 12/02, directed staff to ascertain that the medication package was completely and properly labeled and to review the medication label for resident name, medication name, strength, dosage, expiration date, physician name and direction for administering and to administer medication from labeled containers.	F 431		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a clean and sanitary environment which was maintained in good repair for 4 of 15 resident rooms (142, 146, 148, and 150) observed to be unclean and in disrepair. Findings include:	F 465	Room 142, Room 146, Room 148, and Room 150 will have the gouges on the door sanded down, and re-stained this week. Room 142, Room 146, Room 148, and Room 150 will be re-grouted this week. All rooms in the SNF section will go through this maintenence repair process prior to the end of this calendar year (2016). The repair of the water	2/15/16

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F 465	Continued From page 25 On 1/10/16, at 5:04 p.m. room number 142 was observed to have scratched and gouged bathroom door frames and the tile floor in the bathroom appeared to be unclean. On 1/11/16, at 8:27 a.m. room number 146 and 148 was observed to have scratched and gouged bathroom door frames and the tile floor in the bathrooms appeared to be unclean. Room number 148 had a large white water stain under the back of the toilet. Room number 150 was observed to have a gouge on the inside and outside of the door to the hallway next to the door handle. On 1/13/16, at 10:00 a.m. the director of nursing verified there was a large water spot under the toilet in room number 148 and asked to have further discussion to be held with the housekeeping manager. On 1/13/16, at 10:15 a.m. the health unit coordinator and housekeeping manager also verified there was a large water stain under the toilet in R148 and stated it needed to be cleaned. The housekeeping manager stated the housekeepers mopped the bathroom floors every day and stated the floor was clean but the problem was the grout was stained dark and may appear unclean. On 1/13/16, from 10:15 a.m. until 10:35 a.m. a tour of the facility was conducted with the plant operations director / maintenance director (MD). The MD stated the bathroom floor in room 148 looked terrible and the seal to the toilet was obviously broken and was leaking. The MD stated no one had reported it to maintenance so it was	F 465	stain, toilet leak was repaired the week of the survey. Maintenence will check at each nursing station each day to be sure that leak/repairs are tended to when repairs are needed/reported, and will do random rounds to be assured that this is noticed timely. Maintenence will do a process scheduling so that all rooms can be completed by the end of the year. those rooms in the survey plan will be completed by 02/15/2016	

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F 465	Continued From page 26	F 465		

not fixed. The MD also stated the bathroom tile floors / grout were the original since the building was built in 1977. The MD stated the grout used to be white but was now stained dark brown, all the bathroom floors had stained grout and appeared to be unclean.

The MD also verified the following identified concerns:
· In room 142 bathroom room doorway gouged and scratched.
· In room 148 bathroom doorway gouged and scratched and unclean bathroom floor.
· In room 146 doorframes scratched, bathroom doorway gouged and scratched, bathroom floor looks unclean
· In room 150 a large gouged area on the inside and outside of the door next to the door handle. The director stated that area needed to be sanded and repaired right away before someone got a splinter.

On 1/13/16, at 10:33 a.m. the MD confirmed he had not received maintenance work orders requesting repairs for the above identified concerns and should have.

The facility's undated Maintenance Slip Usage policy indicated the facility would maintain safe, clean and hospitable building and grounds based on Benedictine System's Quality Standard for Plant Operations. (Standard 11: There is a systematic process for identifying, communicating, and completion of plant operations daily intervention in the community.)
Procedure:
1. Plant Operation Supervisor responsible.
2. "Maintenance Slips" will be used for any concerns requiring attention for needs/problems

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245484	A. BUILDING ______ B. WING ______	01/13/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 27 by the maintenance department. 3. Maintenance Slips will be taped on the nurses station as needs occur 4. Maintenance will round daily to pick up slips and proceed as appropriate 5. Prioritization will be based on safety/resident needs	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245484	A. BUILDING **02 - 1975 EAST BUILDING** B. WING	**01/11/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Villa St Vincent was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

Villa St Vincent was built at 4 different times. The 1975 (original) building is 1-story, does not have a basement, was determined to be Type II(000) construction and is separated from the multi-story senior apartment building (1950 building) with at least a 3-hour fire barrier. In 1988 a chapel addition was added to the south west of the original building, is 1-story, no basement, Type V (111) construction and separated with at least a 2-hour fire barrier. In 1993 a 1-story addition was constructed to the north east of the original building, is separated with a 2-hour fire barrier, does not have a basement and was determined to be Type II(111) construction. In 2003 a 1-story addition was constructed to the south of the original building, does not have a basement and was determined to be a Type II (000) construction and is not separated from the original building. The building is divided into 5 smoke zones with 2-hour and 1-hour fire rated barriers.

The facility is protected with a complete automatic sprinkler system installed in accordance with NFPA 13 Installation of Sprinkler Systems 1999 edition. The 1993 and 2003 additions use quick response sprinkler heads.

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245484	A. BUILDING **02 - 1975 EAST BUILDING** B. WING	**01/11/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 The facility has a fire alarm system with corridor smoke detection and smoke detectors in all common areas, installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Addition detectors are in all sleeping rooms of the 1993, 2003 additions and all hazardous areas have automatic detection in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 104 beds and had a census of 101 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		