

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered December 20, 2021

Administrator St Crispin Living Community 213 Pioneer Road Red Wing, MN 55066

RE: CCN: 245449

Cycle Start Date: October 21, 2021

Dear Administrator:

On December 14, 2021, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

M. Paro

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 3, 2021

Administrator St Crispin Living Community 213 Pioneer Road Red Wing, MN 55066

RE: CCN: 245449

Cycle Start Date: October 21, 2021

Dear Administrator:

On October 21, 2021, 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

St Crispin Living Community November 3, 2021 Page 2

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Annette Winters, Rapid Response Unit Supervisor Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us

Mobile: (651) 558-7558

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, 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, 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by January 21, 2022 (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).

St Crispin Living Community November 3, 2021 Page 3

In addition, if substantial compliance with the regulations is not verified by April 21, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html

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,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 04/05/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X: AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245449	B. WING		C 10/21/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 213 PIONEER ROAD RED WING, MN 55066	10/21/2021
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F 000	INITIAL COMMENT	rs	F 00	ס	
	conducted at your f to be NOT in comp	ndard abbreviated survey was acility. Your facility was found liance with the requirements of art B, Requirements for Long s.			
		laint was found to be H5449029C (MN00077238) d at F689.			
	The following comp UNSUBSTANTIATE (MN00074567).	laints were found to be ED: H5449030C			
	as your allegation of Departments accept enrolled in ePOC, year the bottom of the	f correction (POC) will serve of compliance upon the stance. Because you are our signature is not required first page of the CMS-2567 oc submission of the POC will ction of compliance.			
	onsite revisit of you validate that substa regulations has been	azards/Supervision/Devices	F 68	9	11/22/21
		resident receives adequate sistance devices to prevent			
ABORATOR\	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

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

Electronically Signed

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.

11/09/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 689	This REQUIREM by: Based on observe review the facility assess each fall, analyze causal factorder to determininterventions to put falls. Findings include R2's quarterly Mir 8/17/2021, identify hypertension, dial disorder. The MD cognitive impairmextensive assistatoransfers, dressin identified R2 had since the last assequarterly MDS da R2's activities for reviewed/revised required a mecha for transfers, R2 directed staff to oupon demand, be R2's record identified R2 had first in bathroom".	ration, interview, and document failed to comprehensively identify, and comprehensively ctors for potential root cause in e potential individualized revent or decrease the risk for if 3 residents (R2) reviewed for simulation of the factor o	F 68	It is the policy of Benedic Community – Red Wing to Federal, State, and local gand regulations and statur correction is not to be conadmission of deficient prafacility administrator, empor other individuals. The nalleged deficient practice statement of deficiencies constitute agreement with preparations, submission implementation of this plawill serve as our credible compliance. TAG F689 R2's fall care plan was readly interventions in place of and appropriate. Reviewed Reviews of all fall interventions are being conensure appropriate and control interventions are in placed taking place from 11/4/20.11 Licensed staff re-educate Benedictine's post-fall chain immediately following Education started on 10/2	o follow all guidelines, laws tes. This plan of astrued as an actice by the aloyees, agents, esponse to the cited in this does not a citation. The and an of correction allegation of a citation of a		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 689	Continued From p	page 2	F 6	89			
		rs was "Resident Safety		completed by 11/22/2021.			
	report indicated a self-transfers. The intervention was t (medication to rec	t, Altered Gait/Balance." The pattern of R2 falling because of e report indicated an immediate o discontinue oxybutynin duce urinary retention).		IDT process expanded to of each fall during IDT to e cause analysis is complete and ensure that appropria were placed into the care	ensure root ed for all falls te interventions		
	analysis of all pote and implement per prevent and/or redidentified causal flacked evidence of administration redwas not discontinuot include a review	d evidence of a comprehensive ential causal factors to develop ersonalized interventions to duce the risk of falls from factors. R2's care plan also of revision. R2's medication cord revealed R2's Oxybutynin ued until 9/18/21; the record did ew of the effects if any the n R2's self-transfers.		The results of the care pla intervention reviews will be through the facility QA con 12/14/2021 with ongoing f duration to be determined analysis and review of res	e reported mmittee on requency and through		
	indicated R2 had when R2 attempte wheelchair to her included, "resider between bed and back." The reside to her recliner." Totential causal fafactors was "Resi Altered Gait/Balar pattern of R2 fallir indicated an immediate when R2 indicated an immediate recommendation of R2 fallir indicated an immediate recommendation of R2 fallir indicated an immediate recommendation of R2 fallir indicated an immediate recommendation indicated an immediate recommendation in the recommendation in	an unwitnessed fall in her room ed to self-transfer from her recliner. The description of found on floor in room her recliner. Laying on her ent stated she was "trying to go he report had check marks by actors and the evaluation of dent Safety Awareness Deficit, nce. The report indicated a ng was self-transfers. The report ediate intervention was to a of moving resident to a room e station."					
	analysis of all pote and implement pe	d evidence of a comprehensive ential causal factors to develop ersonalized interventions. In e plan did not include and/or terventions.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 689	R2's Event Report indicated R2 had when she attempt wheelchair to her included, "resider between recliner check marks by pevaluation of fact falls related to dia falls do to self-traimpairment, alter awareness, and rechanical stand Nursing to continuand update provid "INTERVENTION recliner in between R2's fall care plar identified R2 was of falls, impaired problems, decreations. The 10/11/21, was "of meals." During an intervied irector of nursing occurred, nurses injury, make the recomplete the incinurse responsible the fall would ider determine the rocimmediate interveresident was supplementations.	rt dated 10/11/21, at 4:09 p.m. an unwitnessed fall in her room ted self-transfer from her recliner. The description at found lying flat on her back in and her bed." The report had botential causal factors and the lors included, R2 was at risk for agnoses, medications, history of insferring, mild cognitive ed balance, poor safety needing assist of one with a for appropriate transfers. Lee to monitor per facility protocol der as needed.	F	689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIR 213 PIONEER ROAD RED WING, MN 55066			
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F 689	DON stated the intreview the post fall in addition to review appropriate interverselicensed practical in fall the nurse assigned to find out what can interventions in plare-occurrence. LPI usually updated with the nursing assistant (of falls; she "has and a lot of things was sometimes concurred to call from the concurrence of the concurrence of falls; she "has and a lot of things was sometimes concurred to call from the concurrence of the concurr	erdisciplinary team would then progress notes every morning wing the care plan to ensure entions were added. You on 10/21/21, at 10:43 a.m. nurse (LPN)-A indicated after a great to that resident would try used the fall and put receive that would prevent the N-A stated the care plan was the that intervention. You on 10/21/21, at 10:49 a.m. NA)-A stated R2 has had lots whole slew of interventions" were in place. NA-A stated R2 infused and didn't always or help and sometimes she relp. NA-A stated R2 didn't she could not get up on her tion on 10/21/21, at 11:00 a.m. reelchair to the nursing station had to use the bathroom. back to her room and assisted 11:57 a.m. R2 sat at the dining sh. At 2:00 p.m. R2 was om sitting in her recliner. You of 10/21/21, at 2:00 p.m. (NA)-B stated R2 had frequent and the stated R2 transfer but now transferred stand-up lift and one staff	F 68	9			

	IENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X:) AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			X3) DATE SURVEY COMPLETED C		
		245449	B. WING _		10)/21/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 213 PIONEER ROAD RED WING, MN 55066		
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F 689	medication change and thinks that may of times R2 attemptindicated the newer assist her to her results as a subsequence 2:22 p.m. (DON) results assist her to her results as a comptoileting and the results as a comptoileting and the results as a comptoileting and the results are results as a comptoileting and assist her to her results as a comptoileting as a comptoileting as a comptoileting as a comptoileting and assist her to her results a comptoileting as a comptoileting as a comptoileting and reduce for the environment of th	dicated R2 may have a se within the last several weeks by have decreased the number of the self-transfers. NA-B set intervention, was for staff to ecliner after meals. The entinterview on 10/21/21, at seviewed R2's record and fall on indicated the causal factors ensively analyzed. DON fall on 9/6/21, R2's record did orehensive assessment of R2's atterns after the fall or after the secontinued and no immediate implemented however, thought self-transfers in the bathroom on indicated after the fall on an was not revised with new of stated the IDT had been be room change, however it mined that would probably onfusion. DON indicated after ediate interventions to prevent risk should have been be presented. The provided results of the second results and the self-transfers in the pathroom of the provided after the fall on an was not revised with new of the self-transfers in the pathroom of the provided after the fall on the self-transfers in the pathroom of the provided after the fall on the provided after the fal	F 68	9		

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F 689	care plan changes additional interven professionals may assessment and/o	s and may if needed implement tions. 13) Additional be contacted to provide or interventions regarding fall ns. 14) documentation of the	F 6	89		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 3, 2021

Administrator St Crispin Living Community 213 Pioneer Road Red Wing, MN 55066

Re: State Nursing Home Licensing Orders

Event ID: RO3L11

Dear Administrator:

The above facility was surveyed on October 21, 2021 through October 21, 2021 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

St Crispin Living Community November 3, 2021 Page 2

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:

Annette Winters, Rapid Response Unit Supervisor Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: apports on winters@state mp.us

Email: annette.m.winters@state.mn.us

Mobile: (651) 558-7558

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

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

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00150	B. WING		10/2	; 1/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1 1412	
ST CRIS	PIN LIVING COMMUN	ITY	EER ROAD G, MN 5506	6		
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2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Departmen	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess					
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	at your facility by su Department of Hea found NOT in comp Licensure. Please in of correction you ha	rS: aplaint survey was conducted irveyors from the Minnesota lth (MDH). Your facility was oliance with the MN State in your electronic planare reviewed these orders and en they will be completed.				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

11/09/21 **Electronically Signed**

TITLE

AND PLAN OF CORRECTION IDENTIFICATION	N NUMBER:	A DIJII DINO.	ECONSTRUCTION	COMPI	SURVEY LETED
		A. BUILDING:			
00150		B. WING		10/2	; 1/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
ST CRISPIN LIVING COMMUNITY	213 PIONEI RED WING,		i.		
(X4) ID SUMMARY STATEMENT OF DEFICIEN PREFIX (EACH DEFICIENCY MUST BE PRECEDED TAG REGULATORY OR LSC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000 Continued From page 1		2 000			
The following complaint was found to SUBSTANTIATED: H5449029C (MN with a licensing order issued at 0830 The following complaint was found to UNSUBSTANTIATED: H5449030C (MN00074567) The Minnesota Department of Health documenting the State Licensing Co Orders using Federal software. Tag have been assigned to Minnesota st statutes/rules for Nursing Homes. The tag number appears in the far-left co "ID Prefix Tag." The state statute/rule compliance is listed in the "Summary of Deficiencies" column and replaced Comply" portion of the correction or column also includes the findings what violation of the state statute after the "This Rule is not met as evidence by the surveyor's findings are the Sugar Method of Correction and Time Perio Correction. You have agreed to participate in the receipt of State licensure orders con the Minnesota Department of Health Informational Bulletin 14-01, available https://www.health.state.mn.us/facion/infobulletins/ib14_1.html> The Storders are delineated on the attache Department of Health orders being syou electronically. Although no plan is necessary for State Statutes/Rules enter the word "CORRECTED" in the available for text. You must then indielectronic State licensure process, u	be be 100077238) be be is rrection numbers ate he assigned plumn entitled be out of y Statement is the "To der. This hich are in a statement, y." Following gested be be detection in the statement with the eat littles/regulating distributed to of correction is, please is box cate in the	2 000			

Minnesota Department of Health

STATE FORM RO3L11 If continuation sheet 2 of 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00150	B. WING		10/2	; 1/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST CRIS	PIN LIVING COMMUN	ITY	EER ROAD	,		
31 OKIS	FIN LIVING COMMON	RED WING	G, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	the Minnesota Depa is enrolled in ePOC	o electronically submitting to artment of Health. The facility and therefore a signature is pottom of the first page of				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE I WHICH STATES, N OF CORRECTION." THIS RAL DEFICIENCIES ONLY. R ON EACH PAGE.				
2 830	MN Rule 4658.0520 Proper Nursing Car	Subp. 1 Adequate and e; General	2 830			11/22/21
	receive nursing care custodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident bed.				
	by: Based on observati review the facility fa assess each fall, ide analyze causal facto order to determine interventions to pre-	ent is not met as evidenced on, interview, and document illed to comprehensively entify, and comprehensively ors for potential root cause in potential individualized vent or decrease the risk for 3 residents (R2) reviewed for		It is the policy of Benedictine Living Community – Red Wing to follow a Federal, State, and local guidelines and regulations and statutes. This correction is not to be construed as admission of deficient practice by t facility administrator, employees, a	ll s, laws plan of s an he	

Minnesota Department of Health

STATE FORM 6899 RO3L11 If continuation sheet 3 of 9

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		20452	B. WING		C
		00150	B. WING		10/21/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE	
ST CRIS	PIN LIVING COMMUN	ITY	EER ROAD G, MN 5506	6	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
2 830	Continued From pa	ge 3	2 830		
	falls. Findings include			or other individuals. The response alleged deficient practice cited in t statement of deficiencies does no constitute agreement with citation.	his t
	8/17/2021, identifie hypertension, diabe disorder. The MDS cognitive impairme	num Data Set (MDS) dated d R2 had diagnosis of etes's, dementia, and anxiety indicated R2 did not have nt, did not walk, and required the from one staff member for		preparations, submission and implementation of this plan of corr will serve as our credible allegatio compliance.	
	identified R2 had 2	and toileting. The MDS or more falls with no injury ssment which was R2's d 5/21/21.		R2's fall care plan was reviewed by All interventions in place remain cannot appropriate. Reviewed on 11/2	urrent 8/2021.
	reviewed/revised or required a mechani for transfers, R2 wa directed staff to offe	aily living care plan last n 8/18/21, indicated R2 cal standing lift with one staff as not ambulatory, and er toileting every 2-3 hours, ween meals, and as needed.		Reviews of all fall interventions ca planned for residents that score as at high risk for falls on the fall risk observation are being conducted t ensure appropriate and current interventions are in place. Review taking place from 11/4/2021 – 11/2	s being so s are
	9/6/2021 and 10/11 R2's Event Report of indicated R2 had an first in bathroom", F to toilet". The report causal factors and contributory factors Awareness Deficit, report indicated a p self-transfers. The intervention was to	ed R2 had 3 falls between /21. dated 9/6/21, at 10:04 p.m. n unwitnessed fall; "Fell face R2 stated she was "transferring thad check marks by multiple the evaluation of potential was "Resident Safety Altered Gait/Balance." The attern of R2 falling because of report indicated an immediate discontinue oxybutynin ce urinary retention).		Licensed staff re-educated on Benedictine's post-fall checklist ar implementation of immediate fall interventions within the resident's plan immediately following a fall. Education started on 10/22/2021 immediately following survey and completed by 11/22/2021. IDT process expanded to include of each fall during IDT to ensure recause analysis is completed for all and ensure that appropriate intervwere placed into the care plan.	care will be a review oot I falls
	analysis of all poter	evidence of a comprehensive itial causal factors to develop sonalized interventions to		The results of the care planned fa intervention reviews will be reporte through the facility QA committee	ed

Minnesota Department of Health

STATE FORM RO3L11 If continuation sheet 4 of 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00150	B. WING		1	21/ 2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ST CRIS	PIN LIVING COMMUN	ITY	EER ROAD			
	T	RED WING	G, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 4	2 830			
	identified causal fact lacked evidence of administration recowas not discontinue not include a review Oxybutynin had on R2's Event Report of indicated R2 had an when R2 attempted wheelchair to her reincluded, "resident between bed and heack." The resident to her recliner." The potential causal factors was "Reside Altered Gait/Balanc pattern of R2 falling indicated an immediate of the service o	dated 9/15/21, at 11:06 p.m. in unwitnessed fall in her room I to self-transfer from her ecliner. The description found on floor in room er recliner. Laying on her a stated she was "trying to go e report had check marks by tors and the evaluation of ent Safety Awareness Deficit, i.e. The report indicated a place was self-transfers. The report liate intervention was to of moving resident to a room		12/14/2021 with ongoing frequence duration to be determined through analysis and review of results.		
	analysis of all poter and implement pers	evidence of a comprehensive atial causal factors to develop sonalized interventions. In plan did not include and/or erventions.				
	indicated R2 had ar when she attempted wheelchair to her re- included, "resident between recliner art check marks by pot evaluation of factors falls related to diagon	dated 10/11/21, at 4:09 p.m. n unwitnessed fall in her room d self-transfer from her ecliner. The description found lying flat on her back in ad her bed." The report had tential causal factors and the is included, R2 was at risk for noses, medications, history of sferring, mild cognitive				

Minnesota Department of Health

STATE FORM RO3L11 If continuation sheet 5 of 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00150	B. WING			C 21/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST CRISPIN LIVING COMMUNITY			EER ROAD 3, MN 55066	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	impairment, altered awareness, and new mechanical stand for Nursing to continue and update provide. "INTERVENTION: orecliner in between R2's fall care plan laidentified R2 was at of falls, impaired ba problems, decrease frequent self-transfer medications. The in 10/11/21, was "offer meals." During an interview director of nursing (occurred, nurses we injury, make the recomplete the incide nurse responsible for the fall would identife determine the root of immediate intervent resident was supported for change DON stated the interview the post fall in addition to review appropriate interver. During an interview licensed practical nurse assign to find out what cau interventions in place."	balance, poor safety eding assist of one with or appropriate transfers. To monitor per facility protocol ras needed. Offer to be transferred to meals." ast revised on 10/11/21, trisk for falls related to history plance, short term memory ed safety awareness with erring, and use of psychotropic plance, streeting, and use of psychotropic protocolor of the resident at the time of the sed to be continuously ges for 72 hours after the fall. Endisciplinary team would then progress notes every morning the care plan to ensure thions were added. on 10/21/21, at 10:43 a.m. purse (LPN)-A indicated after a need to that resident would try sed that would prevent the least attention the care plan was	2 830			

Minnesota Department of Health

STATE FORM RO3L11 If continuation sheet 6 of 9

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00150	B. WING			C 2 1/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ST CRIS	PIN LIVING COMMUN	ITY	EER ROAD			
RED WING			G, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 6	2 830			
	nursing assistant (Nof falls; she "has a wand a lot of things was sometimes corremember to call for would yell out for he always remember sown.	on 10/21/21, at 10:49 a.m. NA)-A stated R2 has had lots whole slew of interventions" were in place. NA-A stated R2 infused and didn't always in help and sometimes sheelp. NA-A stated R2 didn't she could not get up on her iton on 10/21/21, at 11:00 a.m.				
	R2 rolled in her who and told NA-B she I NA-B wheeled R2 b her to the toilet. At room table for lunch	pelchair to the nursing station and to use the bathroom. Dack to her room and assisted 11:57 a.m. R2 sat at the dining an At 2:00 p.m. R2 was a sitting in her recliner.				
	Nursing assistant (If falls with multiple in R2 was a "busy bornot always remember would attempt self-used to be a pivot to with a mechanical smember. NA-B indimedication change and thinks that may of times R2 attempt indicated the newes assist her to her recommend.					
	2:22 p.m. (DON) re incident reports; DO were not comprehe indicated after the f	nt interview on 10/21/21, at viewed R2's record and fall DN indicated the causal factors nsively analyzed. DON all on 9/6/21, R2's record did rehensive assessment of R2's				

Minnesota Department of Health

STATE FORM RO3L11 If continuation sheet 7 of 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
00150		B. WING		C 10/21/2021		
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	10/2	1/2021
		213 PIONE	EER ROAD	STATE, ZIF GODE		
ST CRIS	PIN LIVING COMMUN	ITY	9, MN 55066	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	oxybutynin was discinterventions were in R2's frequency in shad decreased. DC 9/15, R2's care plan interventions, DON evaluating a possib was recently determined and/or reduce their developed and important falls, immediantly policy Integration of a necessary, to maining falls, and reduce fur Post Fall Procedure licensed nurse is not an assessment of the environment of possible contribution. The interdisciplinary care plan changes additional intervention professionals may assessment and/or risk and prevention above items is common SUGGESTED MET The director of nurse review/revise policitials, accidents and proper assessment and pro	terns after the fall or after the continued and no immediate implemented however, thought elf-transfers in the bathroom in Nindicated after the fall on in was not revised with new stated the IDT had been le room change, however it nined that would probably infusion. DON indicated after diate interventions to prevent isk should have been lemented. Trated Fall Management dated collowing: Issessment, identification and appropriate interventions as tain resident safety, prevent in the injury from falls. The nurse completes he resident's condition11) if the fall is evaluated for g factors and addressed. 12.) by team reviews the fall and and may if needed implement in the contacted to provide interventions regarding fall is 14) documentation of the	2 830			

Minnesota Department of Health

STATE FORM RO3L11 If continuation sheet 8 of 9

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
		00150	B. WING			C 21/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
ST CRIS	PIN LIVING COMMUN	II I Y	EER ROAD G, MN 5506	6		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	and monitoring con these policies could results of these aud facility's Quality Ass	ge 8 sistent implementation of the developed, with the dits being brought to the surance Committee for review. R CORRECTION: Twenty-one	2 830	DEFICIENCY)		

Minnesota Department of Health