DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 25, 2022

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

RE: CCN: 245449
Cycle Start Date: July 7, 2022

Dear Administrator:

On August 22, 2022, 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, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 25, 2022

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

Re: Reinspection Results
Event ID: OSWW12

Dear Administrator:

On August 22, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 7, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Electronically delivered
July 21, 2022

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

RE: CCN: 245449
Cycle Start Date: July 7, 2022

Dear Administrator:

On July 7, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), 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:

- 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"and/or an E tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 October 7, 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).

In addition, if substantial compliance with the regulations is not verified by January 7, 2023 (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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 On 7/5/2022, 7/6/2022, and 7/7/2022, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H54492890C (MN00084487), with deficiencies cited at F689 and F690 H54493093C (MN00084143) with deficiencies cited at F689 H5449044C (MN00081010) with deficiencies cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		8/4/22

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

Electronically Signed | 07/28/2022

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
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 689	Continued From page 1 accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow the care plan, failed to complete comprehensive fall assessments for causal factors/root cause and identify care plans were not followed for 2 of 3 residents (R8, R5). The facility's failures resulted in actual harm to R8 when the first fall resulted in head lacerations that required treatment in the emergency room. In addition, the facility failed to ensure a comprehensive fall assessment was completed to ensure safe transfer for R5 following a fall. Findings include: R8's face sheet identified R8 had diagnoses of chronic hypotension, osteoporosis in multiple sites, displaced interochanteric fracture of the left femur and presence of left artificial shoulder joint. R8's discharge, minimum data set (MDS) assessment, dated 5/23/22, identified that R8 was cognitive and had 1 fall with an injury. R8's significant change, MDS assessment, dated 6/2/22, indicated R8's cognition was intact. The MDS identified R8 did not walk, required extensive assist of two staff with bed mobility and was totally dependent on two staff with transfers. R8 had a functional limitation in range of motion in both of his upper extremities and used a wheelchair for mobility. R8's pain management identified that R8 had been on a scheduled pain medication, received PRN (as needed) medications and non-medication interventions for pain, his pain was occasional and moderate and	F 689	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R#8 is no longer a resident of the facility. R#5 investigation and documentation related to the fall event that occurred on 6/27/22 was reviewed and updated by clinical IDT on 7/26/2022 to include newly discovered information and validate an accurate reflection of the fall event including root cause analysis, contributing factors, and subsequent interventions to decrease risk for further falls/accidents. R#5 was reviewed by IDT on 7/27/2022 including completion of bladder assessment, fall risk assessment, and care plan review and revision based on information obtained from assessments. Additionally, the resident was measured to validate proper sling size is in use for surface transfers including toileting. Expanding the group, IDT completed a review of current residents that have the potential to be affected, determining all current residents of the facility were at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 689	Continued From page 2 made it hard to sleep at night. Further identified that R8 had a fall in the last month prior to admit. R8's care plan dated 8/9/21, identified R8 was at risk for falls related to impaired mobility and history of falls; intervention included call light within reach at all times. R8's also identified R8 had a problem with pain due to left shoulder replacement, history of left femur fracture, and impaired mobility; interventions included when R8 expresses pain to offer repositioning, rest. Cold therapy and prn analgesics and to monitor pain every shift. Additionally, R8 required 1-2 staff for assist with bed mobility and assist of 2 with mechanical stand for transfers and did not walk. Review of R8's record identified R8 had falls on 5/15/22 and 6/27/22. During an interview on 7/7/22 at 8:04 a.m. family member (FM)-A stated R8 had told them the night he fell on 5/15/22, he had put on his call light at 3:00 a.m. to get out of bed because his back was hurting. The nursing assistant told him she would be back in a while as they did not have time to get him out of bed. FM-A stated since no one would help him he tried to get himself out of bed and fell to the floor. FM-A stated R8 had to be transferred to the hospital for lacerations. FM-A indicated facility staff were slow at responding to the call lights during the night. During an interview on 7/7/22 at 8:20 a.m. R8 stated he has had back pain for a long time, even before coming to the facility. R8 explained when he was at home he would have back pain during the night; R8 stated he would get out of bed and move around a little bit and go to his recliner. R8 stated he remembered the fall on 5/15/22, stated	F 689	potential risk based on review of resident fall risk observations, fall risk scores, level of assistance needed for transfers and previous fall history. Each resident's care planned fall interventions were reviewed and updated as needed by IDT. Reviews of fall interventions for current residents were completed by 8/4/2022. CNA involved in transfer of resident on 6/27/22 was re-educated by DON on 7/13/2022 in relation to requirement of 2 assist for pivot transfer per resident plan of care as well as with mechanical lift device and following plan of care for all surface transfers and cares. LPN that completed fall event was re-educated by DON on 7/27/2022 in relation to obtaining information from residents and staff post fall in order to assist in determining circumstances of fall as well as root cause in order to ensure accuracy of assessments and plan of care. Clinical leadership team was educated by Regional Director of Clinical Services on 7/19/22 in relation to fall management protocols including completion of investigation and assessments post incident in order to determine contributing factors, root cause, and appropriate interventions to decrease risk to residents. Nursing direct care staff of the facility were educated by DON/Clinical Leadership in relation to fall management protocols including following individual	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 689	Continued From page 3 he had put on his call light around 3:00 a.m. and wanted to get out of bed because his back was hurting. R8 stated a white female responded and told him she was too busy to get him up, would have to wait, and would go tell the nurse his back was hurting. R8 stated he got the Tylenol, did not recall the time, but continued to have back pain. R8 then stated he tried to get out of bed himself because of the pain and fell onto the floor. R8 indicated he does not recall someone sitting him up on the side of the bed. R8 stated since the fall he has had some right shoulder pain as well. R8 indicated he had fallen a second time, didn't remember all the details, but remembered he wanted to sit up because his back was hurting and he had put his call light on. R8's call light log reviewed for 5/15/22, and indicated he had turned his call light on at the following times: -2:46 a.m. and took staff 19 minutes and 57 seconds to respond and were in his room for 15 seconds. -4:28 a.m. and took staff 6 minutes and 7 seconds to respond and were in his room for 9 minutes and 46 seconds. R8's progress note dated 5/15/22, indicated that R8 had complained of lower back ache at 3:40 a.m. and requested some Tylenol, which was somewhat effective. R8's record lacked evidence non-pharmacological interventions were attempted or offered in accordance with the care plan and did not identify what pain control measures were taken after it was identified the Tylenol was somewhat effective. R8's Event Report dated, 5/15/22, at 5:15 a.m. indicated R8 had an unwitnessed fall from his bed	F 689	resident plan of care for transfers, investigation of falls/accidents, interviewing of staff/residents post incident, completion of assessments and identifying contributing factors in order for IDT to determine root cause and appropriate interventions to decrease risk of further falls/accidents/hazards for residents. This education started during survey on 7/7/2022 and will be completed by 8/4/2022. Audits of fall events including investigation and accuracy of assessments will be audited by Clinical RN Managers to validate determination of risk factors, contributing factors, root cause, appropriateness of interventions, and care plan revisions. Audits will be completed 3x weekly x8 weeks, then 2x weekly x2 weeks, then as needed to validate compliance. Audits will be reviewed by DON/designee weekly to validate ongoing and sustained compliance with Plan of Corrections and facility protocols. Audits will be brought through QAPI committee for review and further recommendations. Audits will be discontinued only upon recommendation of QAPI committee once sustained compliance has been determined.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 689	Continued From page 4 (did not identify what time the fall occurred), was observed lying on his right side with his right arm tucked underneath him and a pool of blood under his head. When asked what happened R8 stated that he was sitting on the edge of the bed and had tried to reach for his TV remote so he could then lay back down because his back still hurt, then suddenly he slipped out onto the floor hitting his head on the tray table. R8 had complained of lower back pain from earlier in the night. R8 received two lacerations on his forehead above his right eye and steri strips were applied. R8 complained of being nauseous. When blood was being scrubbed out of his hair R8 vomited clear fluids, MD was notified and R8 was sent to the ED for a CT scan for possible increasing ICP (intracranial pressure). Immediate intervention was to offer to get up at 4:00 a.m. if not already awake. R8's ED Provider Notes, dated 5/15/22, at 6:29 a.m., indicated R8 had a diagnosis of chronic lumbar spinal stenosis and osteoporosis and was being assessed from a fall where R8 stated he was sitting on the side of the bed because of his chronic low back pain where he was leaning on one of the tables and fell hitting the right side of his head on the table. R8 sustained some abrasions and lacerations to the right frontal area, has complaints of neck pain, right shoulder pain and tingling from his elbows to his fingers bilaterally. Noted to have 2 right frontal lacerations that are 3 cm in length with surrounding abrasions and bruising. R8 had labs completed, CT of cervical spine and head without IV contrast and received laceration repaired with Dermabond (surgical skin glue). R8's record lacked a comprehensive fall	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 689	Continued From page 5 assessment; the post fall assessment dated 5/17/22 identified the intervention was to offer to get R8 up at 4:00 a.m. if not already awake even though R8's care plan directed staff to reposition R8 if he were having pain. R8's Event Report, dated 6/27/22, at 4:08 a.m. indicated R8 had an unwitnessed fall from bed and was found on his buttocks next to bed (did not identify what time the fall occurred). R8 stated his call light had fallen to the floor and when he kicked his legs over the side of the bed to get into a sitting position, his pressure reducing boots he was wearing slid him to the floor. Immediate intervention that was placed was to knot the call light to the side rail of bed to prevent it from falling on the floor. R8's call light log reviewed for 6/27/22 and indicated he had turned his call light on at the following times: -12:35 a.m. and took staff 3 minutes and 34 seconds to respond and did not identify any time spent in his room. -3:15 a.m. and took staff 10 minutes and 39 seconds to respond and identified staff spent 25 minutes and 42 seconds in his room. R8's record lacked a comprehensive fall assessment. During an observation on 7/7/22 at 8:02 a.m. R8 sat in his recliner. R8's bed did not have a side rail and the clip to the call light was broken. FM-A stated R8's side rail was removed from his bed 4 days ago, the facility told us the state would not allow side rails because it was against regulation. R8 stated he used the side rail for re-positioning. At 8:21 a.m. maintenance staff entered the room	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 689	Continued From page 6 and put on new bed rail. During an interview on 7/7/22, at 8:04 a.m. licensed practical nurse (LPN)-A indicated she had been R8's nurse the night of 5/15/22. LPN-A was not able to articulate R8's back pain history and stated R8 only had shoulder pain. LPN-A indicated she administered Tylenol at 3:40 a.m., had not attempted non-pharmacological interventions which included repositioning, and at 4:15 a.m. she had went to re-evaluate the effectiveness of the Tylenol. LPN-A stated medication was somewhat effective, so she had instructed the NA's to get R8 out of bed. LPN-A first indicated R8 had been reaching for the remote and slipped on the floor, however then stated R8 had reported to her that he had requested to get out of bed and the NA's had not gotten him up. LPN-A indicated as part of the fall investigation she had not tried to determine how R8 sat up on the side of the bed independently, had not reviewed the call light log, and had not interviewed NA's to ascertain additional causal factors. LPN-A indicated she had revised the care plan without completing a comprehensive fall assessment and the intervention of offering him to get up at 4:00 a.m. came from had the NA's gotten R8 out of bed when he requested the fall would not have occurred. LPN-A stated on 6/27/22 she had also been R8's nurse, R8 had put on his call and when we responded to the call light around 4:00 a.m. he had been on the floor. When asked what R8 had put his call light on for, LPN-A stated an unawareness. LPN-A indicated the root cause was that the call light had fallen on the floor but did not know how the call light got there or if the call light had been secured and within reach prior to the fall. LPN-A indicated she had not interviewed staff for additional causal	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 689	Continued From page 7 factors to ensure appropriate interventions in place to mitigate further risk. During an interview on 7/7/22 at 8:41 a.m. NA-H stated a familiarity with R8. NA-H indicated during the night R8 had pain in his left shoulder, back, right hand/wrist. NA-H indicated warm/cold packs and repositioning were R8's interventions to relieve pain. NA-H stated R8 was an early riser, he was always up at 3:00 a.m., and always wanted to get out of bed because of back pain; that had been his routine since admission last year. NA-H stated he knew he wouldn't have tried to get out of bed himself but thought he had enough upper body strength to pull himself up onto the edge of the bed. During an interview on 7/7/22, at 1:00 p.m. NA-G stated R8 could independently make small position changes in bed however required physical assist of two staff to sit on the edge of the bed. NA-G stated there is no possible way R8 could independently get to a sitting position, someone would have to assist him. NA-G stated she had worked overnight shift on 5/15/22, R8 had put on his call light around 3:00 a.m. and only wanted Tylenol, so she went and told LPN-A. NA-G indicated at about 3:45 right after the Tylenol was given, R8 requested to get out of bed however wanted to give Tylenol time to work. NA-G stated she had not gone back in the room until when she had found him on the floor. NA-G indicated an unawareness of how R8 would have been sitting on the side of the bed according to the fall report and was not aware if another staff member had assisted him. NA-A stated R8 typically got out of bed around 4:00 a.m. and that was his norm., NA-G also indicated R8 typically had back pain at night, but it was usually around	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 689	Continued From page 8 4:00-4:30 not 3:00 a.m. R5 R5's admission Minimum Data Set (MDS), dated 5/3/22, indicated R5 had moderate cognitive impairment and had diagnoses that included cerebral infarction with hemiplegia and hemiparesis, ataxia (loss of coordination of voluntary muscle movements) Alzheimer's disease, stress incontinence. R5 required extensive one assist from staff for dressing and personal hygiene and extensive two assist for bed mobility, transfer, and toilet use. The MDS indicated R5 did not reject/refuse care or other behaviors. . R5's admission fall risk assessment dated 5/3/22, identified R5 was a fall risk, had a history of falls, had functional range of motion limitation of one upper extremity and one lower extremity of the left side related to stroke, and was steady during transfers. R5's care plan dated 4/29/22, identified R5 was not able to walk and directed R5 was a pivot transfer with assist of two staff in the morning except to recliner, which was assist of two with mechanical lift, and in the evening R5 was a assist of two with mechanical lift. The care plan did not identify what type of mechanical lift nor a sling/harness size. R5's care plan also identified R5 was at risk for falls related to cognitive deficit, impaired mobility, and use of psychotropic medications. The fall care plan dated 4/29/22 included the intervention of ensure call light is within reach. R5's fall incident report dated 6/27/22, at 9:29 a.m. indicated R5 was lowered to the floor in her	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 689	Continued From page 9 bathroom after her knees "gave out" while transferring to the toilet. R5 did not sustain injuries. Immediate intervention was R5 downgraded from pivot transfer with two staff to mechanical stand with two assist. R5's corresponding progress note indicated the fall occurred at 9:25 a.m. when two staff pivot transferred R5 off the toilet. R5's record identified R5 had an assisted fall to the floor on 6/27/22 at 9:29 a.m. Interview with facility staff and review the facility's video surveillance did not correlate with the information documented in R5's progress note related to the fall. Video surveillance was watched with facility social worker; video identified only one NA was in the room when R5 had the fall, the NA left the room and shortly thereafter came back to R5's room with another NA. During an interview on 7/7/22, at 10:18 a.m. LPN-A stated she was R5's nurse and completed the incident report. LPN-A stated she had not interviewed the staff involved and assumed two staff were present at the time because when she got to R5's room, there were two aides in the room. LPN-A was not aware NA-B had not followed R5's care plan and transferred R5 by herself. LPN-A stated after the incident she had downgraded R5 to a mechanical standing lift without completing a comprehensive lift assessment prior to changing the care plan and could not articulate what a safe lift assessment consisted of. LPN-A stated she had not consulted with physical or occupation therapy and was not aware that therapy had deemed the standing lift unsafe for R5 to use because of R5's muscle weakness.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 689	Continued From page 10 During an interview on 7/7/22 at 12:30 p.m. NA-C stated she had worked on 6/27/22, NA-C stated NA-B came to get her from the unit she was working on after she had transferred R5 to the toilet by herself. NA-C stated R5 was supposed to use two assist to pivot transfer because her knees get a little wobbly and can't tolerate standing a long time. NA-C indicated R5 was not safe to transfer with one. During an interview on 7/7/22, at 11:25 a.m. occupational therapist (OT) stated she had not been aware R5 had to be lowered to the floor and was not aware nursing had changed R5 to a mechanical standing lift. OT stated nursing should have downgraded R5 to a full body lift because R5 could not tolerate the standing lift related to her ataxia. OT indicated therapy had already determined a standing lift would not have been appropriate for her to use. R5's record identified R5 had another fall on 7/4/22, indicated R5's fall was related to toileting. R5's record lacked a comprehensive fall assessment that identified causal factors/root cause and did not include an evaluation of the effectiveness or appropriateness of R5's toileting program. The fall records indicated R5 had an unwitnessed fall without injury on 7/4/22 at 7:30 p.m. when she had attempted to use her bathroom. R5's progress note dated 7/4/22, included "Resident had attempted to get up out of her wheelchair to use the toilet." Resident's legs could not hold her up and she sat down on the floor. Immediate intervention was to offer R5 toileting immediately after husband leaves room and then assist resident into bed. R5's bladder/bowel care plan dated 4/29/22 (prior	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 689	Continued From page 11 to the fall) identified R5's toileting program was every two to three hours and as needed. Although the R5's record included a bowel/bladder assessment, the assessment was not comprehensive; the assessment did not identify what type of bladder incontinence R5 had or evaluation of R5's toileting routines. During an observation and interview on 7/6/22, at 7:34 a.m. NA-A and NA-B observed performing toileting cares and assisting resident up to wheelchair prior to breakfast. R5 observed heavily incontinent of urine which had soaked through her brief and linens and onto mattress down to her knees. NA-B offered R5 to use bedpan. R5 stated, "I'd rather use the toilet." NA-B stated R5 was unable to use the toilet due to a physical therapy recommendation and wanted her to get stronger before using a toilet. R5 voided a large amount of urine in bedpan. A mechanical full body lift was used to transfer R5 from bed to wheelchair. When interviewed on 7/6/22, at 10:28 a.m. R5 stated she would rather use the bathroom toilet; however, "staff have told me I am unable to use the toilet as they fear I will fall." During an interview on 7/7/22, at 10:18 a.m. LPN-A reviewed R5's record and indicated she had not interviewed nursing staff after the fall and was not aware if R5's toileting plan had been followed. LPN-A further indicated the intervention of toileting R5 after her husband left was implemented without a full investigation and stated a comprehensive bowel/bladder assessment was not completed after the fall. LPN-A stated she would have expected NA's to follow the toileting care plan.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 689	Continued From page 12 On 7/7/22, at 3:09 p.m. director of nursing (DON), social worker (LSW), and regional nurse executive director (RNED) were interviewed. DON stated the expectation the nurse would complete the fall assessment, determine probable root cause, and implement immediate interventions. DON indicated then the interdisciplinary team reviews the fall and determines if the intervention was appropriate and implement additional interventions if necessary. DON stated she expected the nurse(s) to have a fall huddle after the fall to collect information, review the resident record in order to collect pertinent information and that information documented. RNED indicated the facility currently was not using safe mechanical lift transfer assessments and would get those implemented immediately. Facility policy Integrated Fall Management dated 5/6/2021 included Residents are assessed for their risk of falls upon admission, significant change and quarterly thereafter. Residents with risk for falling will have interventions implemented through the resident centered care plan. When a resident experiences a fall, a licensed nurse assesses the residents condition, provides care for, safety and comfort. Post fall Procedure included the following: 7. When a resident falls the licensed nurse is notified. The nurse completes an assessment of the resident's condition including an interview, if possible, completion of vital signs and a body assessment. 8. The medical provider is notified of the fall and resident condition. Orders, if given, are implemented. 9. The resident's representative (as applicable) is	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 689	Continued From page 13 notified of the fall and the resident's condition. 10. The DON and Administrator or their designees are notified of the fall. 11. The environment of the fall is evaluated for possible contributing factors and addressed. 12. The interdisciplinary team reviews the fall and care plan changes and may, if needed, implement additional interventions. 13. Additional professionals may be contacted to provide assessment and/or interventions regarding fall risk and prevention, including but not limited to, attending physician/provider, pharmacist, physical therapist, occupational therapist, and speech therapist. 14. Documentation of the above items is completed.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon	F 690		8/4/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 690	Continued From page 14 as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and document review, the facility failed to complete a comprehensive assessment for individualized toileting program and provide toileting assistance that was dignified, per resident choice, and to prevent urinary tract infections and worsening bladder incontinence to the extent possible for 1 of 1 residents (R5) who was reviewed for falls related to toileting. Findings include: R5's admission Minimum Data Set (MDS), dated 5/3/22, included moderate cognitive impairment with diagnosis including cerebral infarction with hemiplegia and hemiparesis, Alzheimer's disease, dementia, anxiety, stress incontinence, and ataxia. R5 required extensive one assist from staff for dressing and personal hygiene and extensive two assist for bed mobility, transfer, and toilet use. No psychosis, behaviors, rejection of care, or wandering noted on MDS.	F 690	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. Resident #5 was reassessed by clinical RN Manager on 7/19/22. Based on assessment, care plan was updated to reflect current interventions to promote increased continence with staff assistance as well as resident's method of communicating toileting needs. Current residents of the facility requiring assistance of staff for toileting were reviewed by nursing management to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 690	Continued From page 15 R5's toileting care plan dated 4/29/22, directed staff to toilet every two to three hours and as needed to help skin remain free from breakdown. The care plan also directed staff to respect her dignity. The care plan also included R5 required assist of two to get toileting needs addressed. R5 used briefs and the toilet. R5's admission bladder assessment dated 5/3/22, licensed practical nurse (LPN)-A documented R5 was always incontinent of bladder and wears briefs. R5 required staff assist with brief management and hygiene. Staff offer toileting assist every two to three hours and as needed. R5 at risk for incontinence due to diagnosis, medications, and needing assistance with activities of daily living (ADL's) and transferring. R5 denied any bladder issues or difficulties voiding. R5's nursing assistant (NA) daily care card, indicated R5 was assist of two with mechanical stand on dayshift and assist of two with full body mechanical lift on evening and night shift with toileting frequency upon demand. However, therapy orders on R5's closet door directed R5 was a pivot transfer with two staff during the day and full body mechanical lift in the evening. R5's progress note dated 7/5/22, at 4:10 p.m. indicated R5 used assist of two for toileting hygiene, used call light, and requested to be assisted to toilet. During an observation on 7/6/22, at 7:16 a.m. R5 was asleep in bed with door closed. A stale urine odor was present inside room.	F 690	validate accuracy of assessments and resident's current status related to incontinence and assistance to be provided. Direct care nursing staff were educated by nursing management in relation to bladder assessments, toileting needs, and appropriate interventions to promote continence and safety during toileting assistance. This education started during survey on 7/7/2022 and will be completed by 8/4/2022. Audits of bladder assessments and care planned interventions completed and put in place by the clinical managers will be performed by IDT to validate accuracy of the assessments and care plan interventions ensuring a current reflection of resident status related to continence status, resident choice and level of assistance to be provided. Bladder assessment audits will be completed 3x weekly x2 weeks, 2x weekly x2 weeks, then as needed to validate ongoing compliance. DON/designee will review audits weekly to validate compliance with plan of correction. Audits will be brought through QAPI committee for review and further recommendations. Audits will be discontinued only upon recommendation of QAPI committee once sustained compliance has been determined. The achieved compliance will be maintained by quarterly IDT reviews that will include an assessment of resident's bladder assessment, continence status, resident choice and level of assistance provided by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 690	Continued From page 16 During an observation and interview on 7/6/22, at 7:34 a.m. NA-A and NA-B observed performing toileting cares and assisting resident up to wheelchair prior to breakfast. R5 observed heavily incontinent of urine which had soaked through her brief and linens and onto mattress down to her knees. NA-B offered R5 to use bedpan. R5 stated, "I'd rather use the toilet." NA-B stated R5 was unable to use the toilet due to a physical therapy recommendation and wanted her to get stronger before using a toilet. R5 voided a large amount of urine in bedpan. A mechanical lift was used to transfer R5 from bed to wheelchair. When interviewed on 7/6/22, at 10:28 a.m. R5 stated she would rather use the bathroom toilet; however, "staff have told me I am unable to use the toilet as they fear I will fall." When interviewed on 7/6/22, at 10:36 a.m. NA-C stated facility has a toileting sling for mechanical lifts to transfer resident's to toilet. NA-C stated R5 transferred with mechanical lift and two assist. NA-C stated R5 was incontinent at all times. When interviewed on 7/6/22, at 1:58 p.m. physical therapist (PT)-A stated R5 was upgraded on 6/21/22 to stand and pivot with two assist during day shift and use mechanical lift with two assist for evening/night shift. PT-A stated therapy would never tell nursing to not toilet a resident in the bathroom and use a bedpan as that inhibits the rehabilitation process. When interviewed on 7/6/22, at 2:08 p.m. LPN-A stated she expected NA's to find a toileting sling if R5 wanted to use the toilet; however, LPN-A stated R5 was always incontinent and used her	F 690	staff, utilizing resident and staff interviews and point of care charting reviews.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 690	Continued From page 17 brief for toileting. When interviewed on 7/6/22, at 4:51 p.m. director of nursing stated her expectation for nursing staff to assist R5 to the toilet when requested as only allowing R5 to use a bedpan would inhibit resident from meeting her rehabilitation goals and treatment plan. DON stated toileting is always the best option to reinstate a bowel and bladder regimen for residents. When interviewed on 7/7/22, at 8:41 a.m. NA-D stated R5 was continent and alerted staff to when she needed to use the toilet. NA-D stated R5 used a mechanical stand and two assist. NA-D stated R5 was on a toileting two hour round and staff are notified on the call light system when the time period was up. When interviewed on 7/7/22, at 10:18 a.m. LPN-A reviewed R5's record and indicated R5's record did not include an assessment that evaluated R5's toileting patterns and routines, an incontinence diary had not been completed. LPN-A indicated an unawareness R5 had the ability to know when she had to use the toilet and had not completed a comprehensive assessment to determine the extent or reason for R5's incontinence. The policy titled Activities of Daily Living (ADL) dated June 2021, indicated to provide residents with care, treatment, and services appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). -Residents unable to carry out ADL's independently will receive the services necessary to maintain good nutrition, grooming, personal hygiene, elimination, communication, and	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 690	Continued From page 18 mobility. -Care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including support and assistance with: hygiene (bathing, dressing, grooming, and oral care), mobility (transfer and ambulation, including walking), elimination (toileting), dining (meals and snacks, and communication (speech, language, and any functional communication systems). -Interventions to improve and/or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals, and recognized standards of practice. -The resident's response to interventions will be documented, monitored, evaluated, and revised as appropriate.	F 690		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 21, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: OSWW11

Dear Administrator:

The above facility was surveyed on July 5, 2022 through July 7, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/5/2022, 7/6/2022, and 7/7/2022,, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 000	Continued From page 1 when they will be completed. The following complaints were found to be SUBSTANTIATED: H54492890C (MN00084487), with licensing orders at 0830 and 0910 H54493093C (MN00084143) with licensing orders at 0830 H5449044C (MN00081010) with licensing ordrs at 0830 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 000	Continued From page 2 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow the care plan, failed to complete comprehensive fall assessments for causal factors/root cause and identify care plans were not followed for 2 of 3	2 830	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or	8/4/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 830	Continued From page 3 residents (R8, R5). The facility's failures resulted in actual harm to R8 when the first fall resulted in substantial head lacerations that required treatment in the emergency room. In addition, the facility failed to ensure a comprehensive fall assessment was completed to ensure safe transfer for R5 following a fall. Findings include: R8's face sheet identified R8 had diagnoses of chronic hypotension, osteoporosis in multiple sites, displaced interochanteric fracture of the left femur and presence of left artificial shoulder joint. R8's discharge, minimum data set (MDS) assessment, dated 5/23/22, identified that R8 was cognitive and had 1 fall with an injury. R8's significant change, MDS assessment, dated 6/2/22, indicated R8's cognition was intact. The MDS identified R8 did not walk, required extensive assist of two staff with bed mobility and was totally dependent on two staff with transfers. R8 had a functional limitation in range of motion in both of his upper extremities and used a wheelchair for mobility. R8's pain management identified that R8 had been on a scheduled pain medication, received PRN (as needed) medications and non-medication interventions for pain, his pain was occasional and moderate and made it hard to sleep at night. Further identified that R8 had a fall in the last month prior to admit. R8's care plan dated 8/9/21, identified R8 was at risk for falls related to impaired mobility and history of falls; intervention included call light within reach at all times. R8's also identified R8 had a problem with pain due to left shoulder replacement, history of left femur fracture, and	2 830	facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R#8 is no longer a resident of the facility. R#5 investigation and documentation related to the fall event that occurred on 6/27/22 was reviewed and updated by clinical IDT on 7/26/2022 to include newly discovered information and validate an accurate reflection of the fall event including root cause analysis, contributing factors, and subsequent interventions to decrease risk for further falls/accidents. R#5 was reviewed by IDT on 7/27/2022 including completion of bladder assessment, fall risk assessment, and care plan review and revision based on information obtained from assessments. Additionally, the resident was measured to validate proper sling size is in use for surface transfers including toileting. Expanding the group, IDT completed a review of current residents that have the potential to be affected, determining all current residents of the facility were at potential risk based on review of resident fall risk observations, fall risk scores, level of assistance needed for transfers and previous fall history. Each resident's care planned fall interventions were reviewed and updated as needed by IDT. Reviews of fall interventions for current residents were completed by 8/4/2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 830	Continued From page 4 impaired mobility; interventions included when R8 expresses pain to offer repositioning, rest. Cold therapy and prn analgesics and to monitor pain every shift. Additionally, R8 required 1-2 staff for assist with bed mobility and assist of 2 with mechanical stand for transfers and did not walk. Review of R8's record identified R8 had falls on 5/15/22 and 6/27/22. During an interview on 7/7/22 at 8:04 a.m. family member (FM)-A stated R8 had told them the night he fell on 5/15/22, he had put on his call light at 3:00 a.m. to get out of bed because his back was hurting. The nursing assistant told him she would be back in a while as they did not have time to get him out of bed. FM-A stated since no one would help him he tried to get himself out of bed and fell to the floor. FM-A stated R8 had to be transferred to the hospital for lacerations. FM-A indicated facility staff were slow at responding to the call lights during the night. During an interview on 7/7/22 at 8:20 a.m. R8 stated he has had back pain for a long time, even before coming to the facility. R8 explained when he was at home he would have back pain during the night; R8 stated he would get out of bed and move around a little bit and go to his recliner. R8 stated he remembered the fall on 5/15/22, stated he had put on his call light around 3:00 a.m. and wanted to get out of bed because his back was hurting. R8 stated a white female responded and told him she was too busy to get him up, would have to wait, and would go tell the nurse his back was hurting. R8 stated he got the Tylenol, did not recall the time, but continued to have back pain. R8 then stated he tried to get out of bed himself because of the pain and fell onto the floor. R8 indicated he does not recall someone sitting him	2 830	CNA involved in transfer of resident on 6/27/22 was re-educated by DON on 7/13/2022 in relation to requirement of 2 assist for pivot transfer per resident plan of care as well as with mechanical lift device and following plan of care for all surface transfers and cares. LPN that completed fall event was re-educated by DON on 7/27/2022 in relation to obtaining information from residents and staff post fall in order to assist in determining circumstances of fall as well as root cause in order to ensure accuracy of assessments and plan of care. Clinical leadership team was educated by Regional Director of Clinical Services on 7/19/22 in relation to fall management protocols including completion of investigation and assessments post incident in order to determine contributing factors, root cause, and appropriate interventions to decrease risk to residents. Nursing direct care staff of the facility were educated by DON/Clinical Leadership in relation to fall management protocols including following individual resident plan of care for transfers, investigation of falls/accidents, interviewing of staff/residents post incident, completion of assessments and identifying contributing factors in order for IDT to determine root cause and appropriate interventions to decrease risk of further falls/accidents/hazards for residents. This education started during survey on 7/7/2022 and will be completed by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 830	Continued From page 5 up on the side of the bed. R8 stated since the fall he has had some right shoulder pain as well. R8 indicated he had fallen a second time, didn't remember all the details, but remembered he wanted to sit up because his back was hurting and he had put his call light on. R8's call light log reviewed for 5/15/22, and indicated he had turned his call light on at the following times: -2:46 a.m. and took staff 19 minutes and 57 seconds to respond and were in his room for 15 seconds. -4:28 a.m. and took staff 6 minutes and 7 seconds to respond and were in his room for 9 minutes and 46 seconds. R8's progress note dated 5/15/22, indicated that R8 had complained of lower back ache at 3:40 a.m. and requested some Tylenol, which was somewhat effective. R8's record lacked evidence non-pharmacological interventions were attempted or offered in accordance with the care plan and did not identify what pain control measures were taken after it was identified the Tylenol was somewhat effective. R8's Event Report dated, 5/15/22, at 5:15 a.m. indicated R8 had an unwitnessed fall from his bed (did not identify what time the fall occurred), was observed lying on his right side with his right arm tucked underneath him and a pool of blood under his head. When asked what happened R8 stated that he was sitting on the edge of the bed and had tried to reach for his TV remote so he could then lay back down because his back still hurt, then suddenly he slipped out onto the floor hitting his head on the tray table. R8 had complained of lower back pain from earlier in the night. R8 received two lacerations on his forehead above	2 830	8/4/2022. Audits of fall events including investigation and accuracy of assessments will be audited by Clinical RN Managers to validate determination of risk factors, contributing factors, root cause, appropriateness of interventions, and care plan revisions. Audits will be completed 3x weekly x8 weeks, then 2x weekly x2 weeks, then as needed to validate compliance. Audits will be reviewed by DON/designee weekly to validate ongoing and sustained compliance with Plan of Corrections and facility protocols. Audits will be brought through QAPI committee for review and further recommendations. Audits will be discontinued only upon recommendation of QAPI committee once sustained compliance has been determined.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 830	Continued From page 6 his right eye and steri strips were applied. R8 complained of being nauseous. When blood was being scrubbed out of his hair R8 vomited clear fluids, MD was notified and R8 was sent to the ED for a CT scan for possible increasing ICP (intracranial pressure). Immediate intervention was to offer to get up at 4:00 a.m. if not already awake. R8's ED Provider Notes, dated 5/15/22, at 6:29 a.m., indicated R8 had a diagnosis of chronic lumbar spinal stenosis and osteoporosis and was being assessed from a fall where R8 stated he was sitting on the side of the bed because of his chronic low back pain where he was leaning on one of the tables and fell hitting the right side of his head on the table. R8 sustained some abrasions and lacerations to the right frontal area, has complaints of neck pain, right shoulder pain and tingling from his elbows to his fingers bilaterally. Noted to have 2 right frontal lacerations that are 3 cm in length with surrounding abrasions and bruising. R8 had labs completed, CT of cervical spine and head without IV contrast and received laceration repaired with Dermabond (surgical skin glue). R8's record lacked a comprehensive fall assessment; the post fall assessment dated 5/17/22 identified the intervention was to offer to get R8 up at 4:00 a.m. if not already awake even though R8's care plan directed staff to reposition R8 if he were having pain. R8's Event Report, dated 6/27/22, at 4:08 a.m. indicated R8 had an unwitnessed fall from bed and was found on his buttocks next to bed (did not identify what time the fall occurred). R8 stated his call light had fallen to the floor and when he kicked his legs over the side of the bed	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 830	Continued From page 7 to get into a sitting position, his pressure reducing boots he was wearing slid him to the floor. Immediate intervention that was placed was to knot the call light to the side rail of bed to prevent it from falling on the floor. R8's call light log reviewed for 6/27/22 and indicated he had turned his call light on at the following times: -12:35 a.m. and took staff 3 minutes and 34 seconds to respond and did not identify any time spent in his room. -3:15 a.m. and took staff 10 minutes and 39 seconds to respond and identified staff spent 25 minutes and 42 seconds in his room. R8's record lacked a comprehensive fall assessment. During an observation on 7/7/22 at 8:02 a.m. R8 sat in his recliner. R8's bed did not have a side rail and the clip to the call light was broken. FM-A stated R8's side rail was removed from his bed 4 days ago, the facility told us the state would not allow side rails because it was against regulation. R8 stated he used the side rail for re-positioning. At 8:21 a.m. maintenance staff entered the room and put on new bed rail. During an interview on 7/7/22, at 8:04 a.m. licensed practical nurse (LPN)-A indicated she had been R8's nurse the night of 5/15/22. LPN-A was not able to articulate R8's back pain history and stated R8 only had shoulder pain. LPN-A indicated she administered Tylenol at 3:40 a.m., had not attempted non-pharmacological interventions which included repositioning, and at 4:15 a.m. she had went to re-evaluate the effectiveness of the Tylenol. LPN-A stated medication was somewhat effective, so she had	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 830	Continued From page 8 instructed the NA's to get R8 out of bed. LPN-A first indicated R8 had been reaching for the remote and slipped on the floor, however then stated R8 had reported to her that he had requested to get out of bed and the NA's had not gotten him up. LPN-A indicated as part of the fall investigation she had not tried to determine how R8 sat up on the side of the bed independently, had not reviewed the call light log, and had not interviewed NA's to ascertain additional causal factors. LPN-A indicated she had revised the care plan without completing a comprehensive fall assessment and the intervention of offering him to get up at 4:00 a.m. came from had the NA's gotten R8 out of bed when he requested the fall would not have occurred. LPN-A stated on 6/27/22 she had also been R8's nurse, R8 had put on his call and when we responded to the call light around 4:00 a.m. he had been on the floor. When asked what R8 had put his call light on for, LPN-A stated an unawareness. LPN-A indicated the root cause was that the call light had fallen on the floor but did not know how the call light got there or if the call light had been secured and within reach prior to the fall. LPN-A indicated she had not interviewed staff for additional causal factors to ensure appropriate interventions in place to mitigate further risk. During an interview on 7/7/22 at 8:41 a.m. NA-H stated a familiarity with R8. NA-H indicated during the night R8 had pain in his left shoulder, back, right hand/wrist. NA-H indicated warm/cold packs and repositioning were R8's interventions to relieve pain. NA-H stated R8 was an early riser, he was always up at 3:00 a.m., and always wanted to get out of bed because of back pain; that had been his routine since admission last year. NA-H stated he knew he wouldn't have tried to get out of bed himself but thought he had	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 830	Continued From page 9 enough upper body strength to pull himself up onto the edge of the bed. During an interview on 7/7/22, at 1:00 p.m. NA-G stated R8 could independently make small position changes in bed however required physical assist of two staff to sit on the edge of the bed. NA-G stated there is no possible way R8 could independently get to a sitting position, someone would have to assist him. NA-G stated she had worked overnight shift on 5/15/22, R8 had put on his call light around 3:00 a.m. and only wanted Tylenol, so she went and told LPN-A. NA-G indicated at about 3:45 right after the Tylenol was given, R8 requested to get out of bed however wanted to give Tylenol time to work. NA-G stated she had not gone back in the room until when she had found him on the floor. NA-G indicated an unawareness of how R8 would have been sitting on the side of the bed according to the fall report and was not aware if another staff member had assisted him. NA-A stated R8 typically got out of bed around 4:00 a.m. and that was his norm., NA-G also indicated R8 typically had back pain at night, but it was usually around 4:00-4:30 not 3:00 a.m. R5 R5's admission Minimum Data Set (MDS), dated 5/3/22, indicated R5 had moderate cognitive impairment and had diagnoses that included cerebral infarction with hemiplegia and hemiparesis, ataxia (loss of coordination of voluntary muscle movements) Alzheimer's disease, stress incontinence. R5 required extensive one assist from staff for dressing and personal hygiene and extensive two assist for bed mobility, transfer, and toilet use. The MDS indicated R5 did not reject/refuse care or other behaviors. .	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 830	Continued From page 10 R5's admission fall risk assessment dated 5/3/22, identified R5 was a fall risk, had a history of falls, had functional range of motion limitation of one upper extremity and one lower extremity of the left side related to stroke, and was steady during transfers. R5'S care plan dated 4/29/22, identified R5 was not able to walk and directed R5 was a pivot transfer with assist of two staff in the morning except to recliner, which was assist of two with mechanical lift, and in the evening R5 was a assist of two with mechanical lift. The care plan did not identify what type of mechanical lift nor a sling/harness size. R5's care plan also identified R5 was at risk for falls related to cognitive deficit, impaired mobility, and use of psychotropic medications. The fall care plan dated 4/29/22 included the intervention of ensure call light is within reach. R5's fall incident report dated 6/27/22, at 9:29 a.m. indicated R5 was lowered to the floor in her bathroom after her knees "gave out" while transferring to the toilet. R5 did not sustain injuries. Immediate intervention was R5 downgraded from pivot transfer with two staff to mechanical stand with two assist. R5's corresponding progress note indicated the fall occurred at 9:25 a.m. when two staff pivot transferred R5 off the toilet. R5's record identified R5 had an assisted fall to the floor on 6/27/22 at 9:29 a.m. Interview with facility staff and review the facility's video surveillance did not correlate with the information documented in R5's progress note related to the fall. Video surveillance was watched with facility social worker; video identified only one NA was in	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 830	Continued From page 11 the room when R5 had the fall, the NA left the room and shortly thereafter came back to R5's room with another NA. During an interview on 7/7/22, at 10:18 a.m. LPN-A stated she was R5's nurse and completed the incident report. LPN-A stated she had not interviewed the staff involved and assumed two staff were present at the time because when she got to R5's room, there were two aides in the room. LPN-A was not aware NA-B had not followed R5's care plan and transferred R5 by herself. LPN-A stated after the incident she had downgraded R5 to a mechanical standing lift without completing a comprehensive lift assessment prior to changing the care plan and could not articulate what a safe lift assessment consisted of. LPN-A stated she had not consulted with physical or occupation therapy and was not aware that therapy had deemed the standing lift unsafe for R5 to use because of R5's muscle weakness. During an interview on 7/7/22 at 12:30 p.m. NA-C stated she had worked on 6/27/22, NA-C stated NA-B came to get her from the unit she was working on after she had transferred R5 to the toilet by herself. NA-C stated R5 was supposed to use two assist to pivot transfer because her knees get a little wobbly and can't tolerate standing a long time. NA-C indicated R5 was not safe to transfer with one. During an interview on 7/7/22, at 11:25 a.m. occupational therapist (OT) stated she had not been aware R5 had to be lowered to the floor and was not aware nursing had changed R5 to a mechanical standing lift. OT stated nursing should have downgraded R5 to a full body lift because R5 could not tolerate the standing lift	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 830	Continued From page 12 related to her ataxia. OT indicated therapy had already determined a standing lift would not have been appropriate for her to use. R5's record identified R5 had another fall on 7/4/22, indicated R5's fall was related to toileting. R5's record lacked a comprehensive fall assessment that identified causal factors/root cause and did not include an evaluation of the effectiveness or appropriateness of R5's toileting program. The fall records indicated R5 had an unwitnessed fall without injury on 7/4/22 at 7:30 p.m. when she had attempted to use her bathroom. R5's progress note dated 7/4/22, included "Resident had attempted to get up out of her wheelchair to use the toilet." Resident's legs could not hold her up and she sat down on the floor. Immediate intervention was to offer R5 toileting immediately after husband leaves room and then assist resident into bed. R5's bladder/bowel care plan dated 4/29/22 (prior to the fall) identified R5's toileting program was every two to three hours and as needed. Although the R5's record included a bowel/bladder assessment, the assessment was not comprehensive; the assessment did not identify what type of bladder incontinence R5 had or evaluation of R5's toileting routines. During an observation and interview on 7/6/22, at 7:34 a.m. NA-A and NA-B observed performing toileting cares and assisting resident up to wheelchair prior to breakfast. R5 observed heavily incontinent of urine which had soaked through her brief and linens and onto mattress down to her knees. NA-B offered R5 to use bedpan. R5 stated, "I'd rather use the toilet." NA-B stated R5 was unable to use the toilet due to a physical therapy recommendation and	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 830	Continued From page 13 wanted her to get stronger before using a toilet. R5 voided a large amount of urine in bedpan. A mechanical full body lift was used to transfer R5 from bed to wheelchair. When interviewed on 7/6/22, at 10:28 a.m. R5 stated she would rather use the bathroom toilet; however, "staff have told me I am unable to use the toilet as they fear I will fall." During an interview on 7/7/22, at 10:18 a.m. LPN-A reviewed R5's record and indicated she had not interviewed nursing staff after the fall and was not aware if R5's toileting plan had been followed. LPN-A further indicated the intervention of toileting R5 after her husband left was implemented without a full investigation and stated a comprehensive bowel/bladder assessment was not completed after the fall. LPN-A stated she would have expected NA's to follow the toileting care plan. On 7/7/22, at 3:09 p.m. director of nursing (DON), social worker (LSW), and regional nurse executive director (RNED) were interviewed. DON stated the expectation the nurse would complete the fall assessment, determine probable root cause, and implement immediate interventions. DON indicated then the interdisciplinary team reviews the fall and determines if the intervention was appropriate and implement additional interventions if necessary. DON stated she expected the nurse(s) to have a fall huddle after the fall to collect information, review the resident record in order to collect pertinent information and that information documented. RNED indicated the facility currently was not using safe mechanical lift transfer assessments and would get those implemented immediately.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 830	Continued From page 14 Facility policy Integrated Fall Management dated 5/6/2021 included Residents are assessed for their risk of falls upon admission, significant change and quarterly thereafter. Residents with risk for falling will have interventions implemented through the resident centered care plan. When a resident experiences a fall, a licensed nurse assesses the residents condition, provides care for, safety and comfort. Post fall Procedure included the following: 7. When a resident falls the licensed nurse is notified. The nurse completes an assessment of the resident's condition including an interview, if possible, completion of vital signs and a body assessment. 8. The medical provider is notified of the fall and resident condition. Orders, if given, are implemented. 9. The resident's representative (as applicable) is notified of the fall and the resident's condition. 10. The DON and Administrator or their designees are notified of the fall. 11. The environment of the fall is evaluated for possible contributing factors and addressed. 12. The interdisciplinary team reviews the fall and care plan changes and may, if needed, implement additional interventions. 13. Additional professionals may be contacted to provide assessment and/or interventions regarding fall risk and prevention, including but not limited to, attending physician/provider, pharmacist, physical therapist, occupational therapist, and speech therapist. 14. Documentation of the above items is completed.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 830	Continued From page 15 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observations, interview, and document	2 910	This plan of correction constitutes the	8/4/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 910	Continued From page 16 review, the facility failed to complete a comprehensive assessment for individualized toileting program and provide toileting assistance that was dignified, per resident choice, and to prevent urinary tract infections and worsening bladder incontinence to the extent possible for 1 of 1 residents (R5) who was reviewed for falls related to toileting. Findings include: R5's admission Minimum Data Set (MDS), dated 5/3/22, included moderate cognitive impairment with diagnosis including cerebral infarction with hemiplegia and hemiparesis, Alzheimer's disease, dementia, anxiety, stress incontinence, and ataxia. R5 required extensive one assist from staff for dressing and personal hygiene and extensive two assist for bed mobility, transfer, and toilet use. No psychosis, behaviors, rejection of care, or wandering noted on MDS. R5's toileting care plan dated 4/29/22, directed staff to toilet every two to three hours and as needed to help skin remain free from breakdown. The care plan also directed staff to respect her dignity. The care plan also included R5 required assist of two to get toileting needs addressed. R5 used briefs and the toilet. R5's admission bladder assessment dated 5/3/22, licensed practical nurse (LPN)-A documented R5 was always incontinent of bladder and wears briefs. R5 required staff assist with brief management and hygiene. Staff offer toileting assist every two to three hours and as needed. R5 at risk for incontinence due to diagnosis, medications, and needing assistance with activities of daily living (ADL's) and transferring. R5 denied any bladder issues or	2 910	facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. Resident #5 was reassessed by clinical RN Manager on 7/19/22. Based on assessment, care plan was updated to reflect current interventions to promote increased continence with staff assistance as well as resident's method of communicating toileting needs. Current residents of the facility requiring assistance of staff for toileting were reviewed by nursing management to validate accuracy of assessments and resident's current status related to incontinence and assistance to be provided. Direct care nursing staff were educated by nursing management in relation to bladder assessments, toileting needs, and appropriate interventions to promote continence and safety during toileting assistance. This education started during survey on 7/7/2022 and will be completed by 8/4/2022. Audits of bladder assessments and care planned interventions completed and put in place by the clinical managers will be performed by IDT to validate accuracy of the assessments and care plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 910	Continued From page 17 difficulties voiding. R5's nursing assistant (NA) daily care card, indicated R5 was assist of two with mechanical stand on dayshift and assist of two with full body mechanical lift on evening and night shift with toileting frequency upon demand. However, therapy orders on R5's closet door directed R5 was a pivot transfer with two staff during the day and full body mechanical lift in the evening. R5's progress note dated 7/5/22, at 4:10 p.m. indicated R5 used assist of two for toileting hygiene, used call light, and requested to be assisted to toilet. During an observation on 7/6/22, at 7:16 a.m. R5 was asleep in bed with door closed. A stale urine odor was present inside room. During an observation and interview on 7/6/22, at 7:34 a.m. NA-A and NA-B observed performing toileting cares and assisting resident up to wheelchair prior to breakfast. R5 observed heavily incontinent of urine which had soaked through her brief and linens and onto mattress down to her knees. NA-B offered R5 to use bedpan. R5 stated, "I'd rather use the toilet." NA-B stated R5 was unable to use the toilet due to a physical therapy recommendation and wanted her to get stronger before using a toilet. R5 voided a large amount of urine in bedpan. A mechanical lift was used to transfer R5 from bed to wheelchair. When interviewed on 7/6/22, at 10:28 a.m. R5 stated she would rather use the bathroom toilet; however, "staff have told me I am unable to use the toilet as they fear I will fall."	2 910	interventions ensuring a current reflection of resident status related to continence status, resident choice and level of assistance to be provided. Bladder assessment audits will be completed 3x weekly x2 weeks, 2x weekly x2 weeks, then as needed to validate ongoing compliance. DON/designee will review audits weekly to validate compliance with plan of correction. Audits will be brought through QAPI committee for review and further recommendations. Audits will be discontinued only upon recommendation of QAPI committee once sustained compliance has been determined. The achieved compliance will be maintained by quarterly IDT reviews that will include an assessment of resident's bladder assessment, continence status, resident choice and level of assistance provided by staff, utilizing resident and staff interviews and point of care charting reviews.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 910	Continued From page 18 When interviewed on 7/6/22, at 10:36 a.m. NA-C stated facility has a toileting sling for mechanical lifts to transfer resident's to toilet. NA-C stated R5 transferred with mechanical lift and two assist. NA-C stated R5 was incontinent at all times. When interviewed on 7/6/22, at 1:58 p.m. physical therapist (PT)-A stated R5 was upgraded on 6/21/22 to stand and pivot with two assist during day shift and use mechanical lift with two assist for evening/night shift. PT-A stated therapy would never tell nursing to not toilet a resident in the bathroom and use a bedpan as that inhibits the rehabilitation process. When interviewed on 7/6/22, at 2:08 p.m. LPN-A stated she expected NA's to find a toileting sling if R5 wanted to use the toilet; however, LPN-A stated R5 was always incontinent and used her brief for toileting. When interviewed on 7/6/22, at 4:51 p.m. director of nursing stated her expectation for nursing staff to assist R5 to the toilet when requested as only allowing R5 to use a bedpan would inhibit resident from meeting her rehabilitation goals and treatment plan. DON stated toileting is always the best option to reinstate a bowel and bladder regimen for residents. When interviewed on 7/7/22, at 8:41 a.m. NA-D stated R5 was continent and alerted staff to when she needed to use the toilet. NA-D stated R5 used a mechanical stand and two assist. NA-D stated R5 was on a toileting two hour round and staff are notified on the call light system when the time period was up. When interviewed on 7/7/22, at 10:18 a.m. LPN-A reviewed R5's record and indicated R5's record	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 910	Continued From page 19 did not include an assessment that evaluated R5's toileting patterns and routines, an incontinence diary had not been completed. LPN-A indicated an unawareness R5 had the ability to know when she had to use the toilet and had not completed a comprehensive assessment to determine the extent or reason for R5's incontinence. The policy titled Activities of Daily Living (ADL) dated June 2021, indicated to provide residents with care, treatment, and services appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). -Residents unable to carry out ADL's independently will receive the services necessary to maintain good nutrition, grooming, personal hygiene, elimination, communication, and mobility. -Care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including support and assistance with: hygiene (bathing, dressing, grooming, and oral care), mobility (transfer and ambulation, including walking), elimination (toileting), dining (meals and snacks, and communication (speech, language, and any functional communication systems). -Interventions to improve and/or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals, and recognized standards of practice. -The resident's response to interventions will be documented, monitored, evaluated, and revised as appropriate. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 910	Continued From page 20 review and educate responsible staff on comprehensive toileting assessments, and developing individualized toileting program, in addition, to following the toileting program in accordance with the care plan. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		

Electronically delivered
July 21, 2022

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

RE: CCN: 245449
Cycle Start Date: July 7, 2022

Dear Administrator:

On July 7, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), 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:

- 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"and/or an E tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 October 7, 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).

In addition, if substantial compliance with the regulations is not verified by January 7, 2023 (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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 21, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: OSWW11

Dear Administrator:

The above facility was surveyed on July 5, 2022 through July 7, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
July 21, 2022

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

RE: CCN: 245449
Cycle Start Date: July 7, 2022

Dear Administrator:

On July 7, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), 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:

- 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"and/or an E tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 October 7, 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).

In addition, if substantial compliance with the regulations is not verified by January 7, 2023 (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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 21, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: OSWW11

Dear Administrator:

The above facility was surveyed on July 5, 2022 through July 7, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/5/2022, 7/6/2022, and 7/7/2022,, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 000	Continued From page 1 when they will be completed. The following complaints were found to be SUBSTANTIATED: H54492890C (MN00084487), with licensing orders at 0830 and 0910 H54493093C (MN00084143) with licensing orders at 0830 H5449044C (MN00081010) with licensing ordrs at 0830 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 000	Continued From page 2 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow the care plan, failed to complete comprehensive fall assessments for causal factors/root cause and identify care plans were not followed for 2 of 3	2 830	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or	8/4/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 830	Continued From page 3 residents (R8, R5). The facility's failures resulted in actual harm to R8 when the first fall resulted in substantial head lacerations that required treatment in the emergency room. In addition, the facility failed to ensure a comprehensive fall assessment was completed to ensure safe transfer for R5 following a fall. Findings include: R8's face sheet identified R8 had diagnoses of chronic hypotension, osteoporosis in multiple sites, displaced interochanteric fracture of the left femur and presence of left artificial shoulder joint. R8's discharge, minimum data set (MDS) assessment, dated 5/23/22, identified that R8 was cognitive and had 1 fall with an injury. R8's significant change, MDS assessment, dated 6/2/22, indicated R8's cognition was intact. The MDS identified R8 did not walk, required extensive assist of two staff with bed mobility and was totally dependent on two staff with transfers. R8 had a functional limitation in range of motion in both of his upper extremities and used a wheelchair for mobility. R8's pain management identified that R8 had been on a scheduled pain medication, received PRN (as needed) medications and non-medication interventions for pain, his pain was occasional and moderate and made it hard to sleep at night. Further identified that R8 had a fall in the last month prior to admit. R8's care plan dated 8/9/21, identified R8 was at risk for falls related to impaired mobility and history of falls; intervention included call light within reach at all times. R8's also identified R8 had a problem with pain due to left shoulder replacement, history of left femur fracture, and	2 830	facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R#8 is no longer a resident of the facility. R#5 investigation and documentation related to the fall event that occurred on 6/27/22 was reviewed and updated by clinical IDT on 7/26/2022 to include newly discovered information and validate an accurate reflection of the fall event including root cause analysis, contributing factors, and subsequent interventions to decrease risk for further falls/accidents. R#5 was reviewed by IDT on 7/27/2022 including completion of bladder assessment, fall risk assessment, and care plan review and revision based on information obtained from assessments. Additionally, the resident was measured to validate proper sling size is in use for surface transfers including toileting. Expanding the group, IDT completed a review of current residents that have the potential to be affected, determining all current residents of the facility were at potential risk based on review of resident fall risk observations, fall risk scores, level of assistance needed for transfers and previous fall history. Each resident's care planned fall interventions were reviewed and updated as needed by IDT. Reviews of fall interventions for current residents were completed by 8/4/2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 830	Continued From page 4 impaired mobility; interventions included when R8 expresses pain to offer repositioning, rest. Cold therapy and prn analgesics and to monitor pain every shift. Additionally, R8 required 1-2 staff for assist with bed mobility and assist of 2 with mechanical stand for transfers and did not walk. Review of R8's record identified R8 had falls on 5/15/22 and 6/27/22. During an interview on 7/7/22 at 8:04 a.m. family member (FM)-A stated R8 had told them the night he fell on 5/15/22, he had put on his call light at 3:00 a.m. to get out of bed because his back was hurting. The nursing assistant told him she would be back in a while as they did not have time to get him out of bed. FM-A stated since no one would help him he tried to get himself out of bed and fell to the floor. FM-A stated R8 had to be transferred to the hospital for lacerations. FM-A indicated facility staff were slow at responding to the call lights during the night. During an interview on 7/7/22 at 8:20 a.m. R8 stated he has had back pain for a long time, even before coming to the facility. R8 explained when he was at home he would have back pain during the night; R8 stated he would get out of bed and move around a little bit and go to his recliner. R8 stated he remembered the fall on 5/15/22, stated he had put on his call light around 3:00 a.m. and wanted to get out of bed because his back was hurting. R8 stated a white female responded and told him she was too busy to get him up, would have to wait, and would go tell the nurse his back was hurting. R8 stated he got the Tylenol, did not recall the time, but continued to have back pain. R8 then stated he tried to get out of bed himself because of the pain and fell onto the floor. R8 indicated he does not recall someone sitting him	2 830	CNA involved in transfer of resident on 6/27/22 was re-educated by DON on 7/13/2022 in relation to requirement of 2 assist for pivot transfer per resident plan of care as well as with mechanical lift device and following plan of care for all surface transfers and cares. LPN that completed fall event was re-educated by DON on 7/27/2022 in relation to obtaining information from residents and staff post fall in order to assist in determining circumstances of fall as well as root cause in order to ensure accuracy of assessments and plan of care. Clinical leadership team was educated by Regional Director of Clinical Services on 7/19/22 in relation to fall management protocols including completion of investigation and assessments post incident in order to determine contributing factors, root cause, and appropriate interventions to decrease risk to residents. Nursing direct care staff of the facility were educated by DON/Clinical Leadership in relation to fall management protocols including following individual resident plan of care for transfers, investigation of falls/accidents, interviewing of staff/residents post incident, completion of assessments and identifying contributing factors in order for IDT to determine root cause and appropriate interventions to decrease risk of further falls/accidents/hazards for residents. This education started during survey on 7/7/2022 and will be completed by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 830	Continued From page 5 up on the side of the bed. R8 stated since the fall he has had some right shoulder pain as well. R8 indicated he had fallen a second time, didn't remember all the details, but remembered he wanted to sit up because his back was hurting and he had put his call light on. R8's call light log reviewed for 5/15/22, and indicated he had turned his call light on at the following times: -2:46 a.m. and took staff 19 minutes and 57 seconds to respond and were in his room for 15 seconds. -4:28 a.m. and took staff 6 minutes and 7 seconds to respond and were in his room for 9 minutes and 46 seconds. R8's progress note dated 5/15/22, indicated that R8 had complained of lower back ache at 3:40 a.m. and requested some Tylenol, which was somewhat effective. R8's record lacked evidence non-pharmacological interventions were attempted or offered in accordance with the care plan and did not identify what pain control measures were taken after it was identified the Tylenol was somewhat effective. R8's Event Report dated, 5/15/22, at 5:15 a.m. indicated R8 had an unwitnessed fall from his bed (did not identify what time the fall occurred), was observed lying on his right side with his right arm tucked underneath him and a pool of blood under his head. When asked what happened R8 stated that he was sitting on the edge of the bed and had tried to reach for his TV remote so he could then lay back down because his back still hurt, then suddenly he slipped out onto the floor hitting his head on the tray table. R8 had complained of lower back pain from earlier in the night. R8 received two lacerations on his forehead above	2 830	8/4/2022. Audits of fall events including investigation and accuracy of assessments will be audited by Clinical RN Managers to validate determination of risk factors, contributing factors, root cause, appropriateness of interventions, and care plan revisions. Audits will be completed 3x weekly x8 weeks, then 2x weekly x2 weeks, then as needed to validate compliance. Audits will be reviewed by DON/designee weekly to validate ongoing and sustained compliance with Plan of Corrections and facility protocols. Audits will be brought through QAPI committee for review and further recommendations. Audits will be discontinued only upon recommendation of QAPI committee once sustained compliance has been determined.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 830	Continued From page 6 his right eye and steri strips were applied. R8 complained of being nauseous. When blood was being scrubbed out of his hair R8 vomited clear fluids, MD was notified and R8 was sent to the ED for a CT scan for possible increasing ICP (intracranial pressure). Immediate intervention was to offer to get up at 4:00 a.m. if not already awake. R8's ED Provider Notes, dated 5/15/22, at 6:29 a.m., indicated R8 had a diagnosis of chronic lumbar spinal stenosis and osteoporosis and was being assessed from a fall where R8 stated he was sitting on the side of the bed because of his chronic low back pain where he was leaning on one of the tables and fell hitting the right side of his head on the table. R8 sustained some abrasions and lacerations to the right frontal area, has complaints of neck pain, right shoulder pain and tingling from his elbows to his fingers bilaterally. Noted to have 2 right frontal lacerations that are 3 cm in length with surrounding abrasions and bruising. R8 had labs completed, CT of cervical spine and head without IV contrast and received laceration repaired with Dermabond (surgical skin glue). R8's record lacked a comprehensive fall assessment; the post fall assessment dated 5/17/22 identified the intervention was to offer to get R8 up at 4:00 a.m. if not already awake even though R8's care plan directed staff to reposition R8 if he were having pain. R8's Event Report, dated 6/27/22, at 4:08 a.m. indicated R8 had an unwitnessed fall from bed and was found on his buttocks next to bed (did not identify what time the fall occurred). R8 stated his call light had fallen to the floor and when he kicked his legs over the side of the bed	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 830	Continued From page 7 to get into a sitting position, his pressure reducing boots he was wearing slid him to the floor. Immediate intervention that was placed was to knot the call light to the side rail of bed to prevent it from falling on the floor. R8's call light log reviewed for 6/27/22 and indicated he had turned his call light on at the following times: -12:35 a.m. and took staff 3 minutes and 34 seconds to respond and did not identify any time spent in his room. -3:15 a.m. and took staff 10 minutes and 39 seconds to respond and identified staff spent 25 minutes and 42 seconds in his room. R8's record lacked a comprehensive fall assessment. During an observation on 7/7/22 at 8:02 a.m. R8 sat in his recliner. R8's bed did not have a side rail and the clip to the call light was broken. FM-A stated R8's side rail was removed from his bed 4 days ago, the facility told us the state would not allow side rails because it was against regulation. R8 stated he used the side rail for re-positioning. At 8:21 a.m. maintenance staff entered the room and put on new bed rail. During an interview on 7/7/22, at 8:04 a.m. licensed practical nurse (LPN)-A indicated she had been R8's nurse the night of 5/15/22. LPN-A was not able to articulate R8's back pain history and stated R8 only had shoulder pain. LPN-A indicated she administered Tylenol at 3:40 a.m., had not attempted non-pharmacological interventions which included repositioning, and at 4:15 a.m. she had went to re-evaluate the effectiveness of the Tylenol. LPN-A stated medication was somewhat effective, so she had	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 830	Continued From page 8 instructed the NA's to get R8 out of bed. LPN-A first indicated R8 had been reaching for the remote and slipped on the floor, however then stated R8 had reported to her that he had requested to get out of bed and the NA's had not gotten him up. LPN-A indicated as part of the fall investigation she had not tried to determine how R8 sat up on the side of the bed independently, had not reviewed the call light log, and had not interviewed NA's to ascertain additional causal factors. LPN-A indicated she had revised the care plan without completing a comprehensive fall assessment and the intervention of offering him to get up at 4:00 a.m. came from had the NA's gotten R8 out of bed when he requested the fall would not have occurred. LPN-A stated on 6/27/22 she had also been R8's nurse, R8 had put on his call and when we responded to the call light around 4:00 a.m. he had been on the floor. When asked what R8 had put his call light on for, LPN-A stated an unawareness. LPN-A indicated the root cause was that the call light had fallen on the floor but did not know how the call light got there or if the call light had been secured and within reach prior to the fall. LPN-A indicated she had not interviewed staff for additional causal factors to ensure appropriate interventions in place to mitigate further risk. During an interview on 7/7/22 at 8:41 a.m. NA-H stated a familiarity with R8. NA-H indicated during the night R8 had pain in his left shoulder, back, right hand/wrist. NA-H indicated warm/cold packs and repositioning were R8's interventions to relieve pain. NA-H stated R8 was an early riser, he was always up at 3:00 a.m., and always wanted to get out of bed because of back pain; that had been his routine since admission last year. NA-H stated he knew he wouldn't have tried to get out of bed himself but thought he had	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 830	Continued From page 9 enough upper body strength to pull himself up onto the edge of the bed. During an interview on 7/7/22, at 1:00 p.m. NA-G stated R8 could independently make small position changes in bed however required physical assist of two staff to sit on the edge of the bed. NA-G stated there is no possible way R8 could independently get to a sitting position, someone would have to assist him. NA-G stated she had worked overnight shift on 5/15/22, R8 had put on his call light around 3:00 a.m. and only wanted Tylenol, so she went and told LPN-A. NA-G indicated at about 3:45 right after the Tylenol was given, R8 requested to get out of bed however wanted to give Tylenol time to work. NA-G stated she had not gone back in the room until when she had found him on the floor. NA-G indicated an unawareness of how R8 would have been sitting on the side of the bed according to the fall report and was not aware if another staff member had assisted him. NA-A stated R8 typically got out of bed around 4:00 a.m. and that was his norm., NA-G also indicated R8 typically had back pain at night, but it was usually around 4:00-4:30 not 3:00 a.m. R5 R5's admission Minimum Data Set (MDS), dated 5/3/22, indicated R5 had moderate cognitive impairment and had diagnoses that included cerebral infarction with hemiplegia and hemiparesis, ataxia (loss of coordination of voluntary muscle movements) Alzheimer's disease, stress incontinence. R5 required extensive one assist from staff for dressing and personal hygiene and extensive two assist for bed mobility, transfer, and toilet use. The MDS indicated R5 did not reject/refuse care or other behaviors. .	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 830	Continued From page 10 R5's admission fall risk assessment dated 5/3/22, identified R5 was a fall risk, had a history of falls, had functional range of motion limitation of one upper extremity and one lower extremity of the left side related to stroke, and was steady during transfers. R5'S care plan dated 4/29/22, identified R5 was not able to walk and directed R5 was a pivot transfer with assist of two staff in the morning except to recliner, which was assist of two with mechanical lift, and in the evening R5 was a assist of two with mechanical lift. The care plan did not identify what type of mechanical lift nor a sling/harness size. R5's care plan also identified R5 was at risk for falls related to cognitive deficit, impaired mobility, and use of psychotropic medications. The fall care plan dated 4/29/22 included the intervention of ensure call light is within reach. R5's fall incident report dated 6/27/22, at 9:29 a.m. indicated R5 was lowered to the floor in her bathroom after her knees "gave out" while transferring to the toilet. R5 did not sustain injuries. Immediate intervention was R5 downgraded from pivot transfer with two staff to mechanical stand with two assist. R5's corresponding progress note indicated the fall occurred at 9:25 a.m. when two staff pivot transferred R5 off the toilet. R5's record identified R5 had an assisted fall to the floor on 6/27/22 at 9:29 a.m. Interview with facility staff and review the facility's video surveillance did not correlate with the information documented in R5's progress note related to the fall. Video surveillance was watched with facility social worker; video identified only one NA was in	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 830	Continued From page 11 the room when R5 had the fall, the NA left the room and shortly thereafter came back to R5's room with another NA. During an interview on 7/7/22, at 10:18 a.m. LPN-A stated she was R5's nurse and completed the incident report. LPN-A stated she had not interviewed the staff involved and assumed two staff were present at the time because when she got to R5's room, there were two aides in the room. LPN-A was not aware NA-B had not followed R5's care plan and transferred R5 by herself. LPN-A stated after the incident she had downgraded R5 to a mechanical standing lift without completing a comprehensive lift assessment prior to changing the care plan and could not articulate what a safe lift assessment consisted of. LPN-A stated she had not consulted with physical or occupation therapy and was not aware that therapy had deemed the standing lift unsafe for R5 to use because of R5's muscle weakness. During an interview on 7/7/22 at 12:30 p.m. NA-C stated she had worked on 6/27/22, NA-C stated NA-B came to get her from the unit she was working on after she had transferred R5 to the toilet by herself. NA-C stated R5 was supposed to use two assist to pivot transfer because her knees get a little wobbly and can't tolerate standing a long time. NA-C indicated R5 was not safe to transfer with one. During an interview on 7/7/22, at 11:25 a.m. occupational therapist (OT) stated she had not been aware R5 had to be lowered to the floor and was not aware nursing had changed R5 to a mechanical standing lift. OT stated nursing should have downgraded R5 to a full body lift because R5 could not tolerate the standing lift	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 830	Continued From page 12 related to her ataxia. OT indicated therapy had already determined a standing lift would not have been appropriate for her to use. R5's record identified R5 had another fall on 7/4/22, indicated R5's fall was related to toileting. R5's record lacked a comprehensive fall assessment that identified causal factors/root cause and did not include an evaluation of the effectiveness or appropriateness of R5's toileting program. The fall records indicated R5 had an unwitnessed fall without injury on 7/4/22 at 7:30 p.m. when she had attempted to use her bathroom. R5's progress note dated 7/4/22, included "Resident had attempted to get up out of her wheelchair to use the toilet." Resident's legs could not hold her up and she sat down on the floor. Immediate intervention was to offer R5 toileting immediately after husband leaves room and then assist resident into bed. R5's bladder/bowel care plan dated 4/29/22 (prior to the fall) identified R5's toileting program was every two to three hours and as needed. Although the R5's record included a bowel/bladder assessment, the assessment was not comprehensive; the assessment did not identify what type of bladder incontinence R5 had or evaluation of R5's toileting routines. During an observation and interview on 7/6/22, at 7:34 a.m. NA-A and NA-B observed performing toileting cares and assisting resident up to wheelchair prior to breakfast. R5 observed heavily incontinent of urine which had soaked through her brief and linens and onto mattress down to her knees. NA-B offered R5 to use bedpan. R5 stated, "I'd rather use the toilet." NA-B stated R5 was unable to use the toilet due to a physical therapy recommendation and	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 830	Continued From page 13 wanted her to get stronger before using a toilet. R5 voided a large amount of urine in bedpan. A mechanical full body lift was used to transfer R5 from bed to wheelchair. When interviewed on 7/6/22, at 10:28 a.m. R5 stated she would rather use the bathroom toilet; however, "staff have told me I am unable to use the toilet as they fear I will fall." During an interview on 7/7/22, at 10:18 a.m. LPN-A reviewed R5's record and indicated she had not interviewed nursing staff after the fall and was not aware if R5's toileting plan had been followed. LPN-A further indicated the intervention of toileting R5 after her husband left was implemented without a full investigation and stated a comprehensive bowel/bladder assessment was not completed after the fall. LPN-A stated she would have expected NA's to follow the toileting care plan. On 7/7/22, at 3:09 p.m. director of nursing (DON), social worker (LSW), and regional nurse executive director (RNED) were interviewed. DON stated the expectation the nurse would complete the fall assessment, determine probable root cause, and implement immediate interventions. DON indicated then the interdisciplinary team reviews the fall and determines if the intervention was appropriate and implement additional interventions if necessary. DON stated she expected the nurse(s) to have a fall huddle after the fall to collect information, review the resident record in order to collect pertinent information and that information documented. RNED indicated the facility currently was not using safe mechanical lift transfer assessments and would get those implemented immediately.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 830	Continued From page 14 Facility policy Integrated Fall Management dated 5/6/2021 included Residents are assessed for their risk of falls upon admission, significant change and quarterly thereafter. Residents with risk for falling will have interventions implemented through the resident centered care plan. When a resident experiences a fall, a licensed nurse assesses the residents condition, provides care for, safety and comfort. Post fall Procedure included the following: 7. When a resident falls the licensed nurse is notified. The nurse completes an assessment of the resident's condition including an interview, if possible, completion of vital signs and a body assessment. 8. The medical provider is notified of the fall and resident condition. Orders, if given, are implemented. 9. The resident's representative (as applicable) is notified of the fall and the resident's condition. 10. The DON and Administrator or their designees are notified of the fall. 11. The environment of the fall is evaluated for possible contributing factors and addressed. 12. The interdisciplinary team reviews the fall and care plan changes and may, if needed, implement additional interventions. 13. Additional professionals may be contacted to provide assessment and/or interventions regarding fall risk and prevention, including but not limited to, attending physician/provider, pharmacist, physical therapist, occupational therapist, and speech therapist. 14. Documentation of the above items is completed.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 830	Continued From page 15 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observations, interview, and document	2 910	This plan of correction constitutes the	8/4/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 910	Continued From page 16 review, the facility failed to complete a comprehensive assessment for individualized toileting program and provide toileting assistance that was dignified, per resident choice, and to prevent urinary tract infections and worsening bladder incontinence to the extent possible for 1 of 1 residents (R5) who was reviewed for falls related to toileting. Findings include: R5's admission Minimum Data Set (MDS), dated 5/3/22, included moderate cognitive impairment with diagnosis including cerebral infarction with hemiplegia and hemiparesis, Alzheimer's disease, dementia, anxiety, stress incontinence, and ataxia. R5 required extensive one assist from staff for dressing and personal hygiene and extensive two assist for bed mobility, transfer, and toilet use. No psychosis, behaviors, rejection of care, or wandering noted on MDS. R5's toileting care plan dated 4/29/22, directed staff to toilet every two to three hours and as needed to help skin remain free from breakdown. The care plan also directed staff to respect her dignity. The care plan also included R5 required assist of two to get toileting needs addressed. R5 used briefs and the toilet. R5's admission bladder assessment dated 5/3/22, licensed practical nurse (LPN)-A documented R5 was always incontinent of bladder and wears briefs. R5 required staff assist with brief management and hygiene. Staff offer toileting assist every two to three hours and as needed. R5 at risk for incontinence due to diagnosis, medications, and needing assistance with activities of daily living (ADL's) and transferring. R5 denied any bladder issues or	2 910	facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. Resident #5 was reassessed by clinical RN Manager on 7/19/22. Based on assessment, care plan was updated to reflect current interventions to promote increased continence with staff assistance as well as resident's method of communicating toileting needs. Current residents of the facility requiring assistance of staff for toileting were reviewed by nursing management to validate accuracy of assessments and resident's current status related to incontinence and assistance to be provided. Direct care nursing staff were educated by nursing management in relation to bladder assessments, toileting needs, and appropriate interventions to promote continence and safety during toileting assistance. This education started during survey on 7/7/2022 and will be completed by 8/4/2022. Audits of bladder assessments and care planned interventions completed and put in place by the clinical managers will be performed by IDT to validate accuracy of the assessments and care plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 910	Continued From page 17 difficulties voiding. R5's nursing assistant (NA) daily care card, indicated R5 was assist of two with mechanical stand on dayshift and assist of two with full body mechanical lift on evening and night shift with toileting frequency upon demand. However, therapy orders on R5's closet door directed R5 was a pivot transfer with two staff during the day and full body mechanical lift in the evening. R5's progress note dated 7/5/22, at 4:10 p.m. indicated R5 used assist of two for toileting hygiene, used call light, and requested to be assisted to toilet. During an observation on 7/6/22, at 7:16 a.m. R5 was asleep in bed with door closed. A stale urine odor was present inside room. During an observation and interview on 7/6/22, at 7:34 a.m. NA-A and NA-B observed performing toileting cares and assisting resident up to wheelchair prior to breakfast. R5 observed heavily incontinent of urine which had soaked through her brief and linens and onto mattress down to her knees. NA-B offered R5 to use bedpan. R5 stated, "I'd rather use the toilet." NA-B stated R5 was unable to use the toilet due to a physical therapy recommendation and wanted her to get stronger before using a toilet. R5 voided a large amount of urine in bedpan. A mechanical lift was used to transfer R5 from bed to wheelchair. When interviewed on 7/6/22, at 10:28 a.m. R5 stated she would rather use the bathroom toilet; however, "staff have told me I am unable to use the toilet as they fear I will fall."	2 910	interventions ensuring a current reflection of resident status related to continence status, resident choice and level of assistance to be provided. Bladder assessment audits will be completed 3x weekly x2 weeks, 2x weekly x2 weeks, then as needed to validate ongoing compliance. DON/designee will review audits weekly to validate compliance with plan of correction. Audits will be brought through QAPI committee for review and further recommendations. Audits will be discontinued only upon recommendation of QAPI committee once sustained compliance has been determined. The achieved compliance will be maintained by quarterly IDT reviews that will include an assessment of resident's bladder assessment, continence status, resident choice and level of assistance provided by staff, utilizing resident and staff interviews and point of care charting reviews.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 910	Continued From page 18 When interviewed on 7/6/22, at 10:36 a.m. NA-C stated facility has a toileting sling for mechanical lifts to transfer resident's to toilet. NA-C stated R5 transferred with mechanical lift and two assist. NA-C stated R5 was incontinent at all times. When interviewed on 7/6/22, at 1:58 p.m. physical therapist (PT)-A stated R5 was upgraded on 6/21/22 to stand and pivot with two assist during day shift and use mechanical lift with two assist for evening/night shift. PT-A stated therapy would never tell nursing to not toilet a resident in the bathroom and use a bedpan as that inhibits the rehabilitation process. When interviewed on 7/6/22, at 2:08 p.m. LPN-A stated she expected NA's to find a toileting sling if R5 wanted to use the toilet; however, LPN-A stated R5 was always incontinent and used her brief for toileting. When interviewed on 7/6/22, at 4:51 p.m. director of nursing stated her expectation for nursing staff to assist R5 to the toilet when requested as only allowing R5 to use a bedpan would inhibit resident from meeting her rehabilitation goals and treatment plan. DON stated toileting is always the best option to reinstate a bowel and bladder regimen for residents. When interviewed on 7/7/22, at 8:41 a.m. NA-D stated R5 was continent and alerted staff to when she needed to use the toilet. NA-D stated R5 used a mechanical stand and two assist. NA-D stated R5 was on a toileting two hour round and staff are notified on the call light system when the time period was up. When interviewed on 7/7/22, at 10:18 a.m. LPN-A reviewed R5's record and indicated R5's record	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 910	Continued From page 19 did not include an assessment that evaluated R5's toileting patterns and routines, an incontinence diary had not been completed. LPN-A indicated an unawareness R5 had the ability to know when she had to use the toilet and had not completed a comprehensive assessment to determine the extent or reason for R5's incontinence. The policy titled Activities of Daily Living (ADL) dated June 2021, indicated to provide residents with care, treatment, and services appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). -Residents unable to carry out ADL's independently will receive the services necessary to maintain good nutrition, grooming, personal hygiene, elimination, communication, and mobility. -Care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including support and assistance with: hygiene (bathing, dressing, grooming, and oral care), mobility (transfer and ambulation, including walking), elimination (toileting), dining (meals and snacks, and communication (speech, language, and any functional communication systems). -Interventions to improve and/or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals, and recognized standards of practice. -The resident's response to interventions will be documented, monitored, evaluated, and revised as appropriate. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00150	A. BUILDING: _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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) COMPLETE DATE
2 910	Continued From page 20 review and educate responsible staff on comprehensive toileting assessments, and developing individualized toileting program, in addition, to following the toileting program in accordance with the care plan. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 On 7/5/2022, 7/6/2022, and 7/7/2022, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H54492890C (MN00084487), with deficiencies cited at F689 and F690 H54493093C (MN00084143) with deficiencies cited at F689 H5449044C (MN00081010) with deficiencies cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		8/4/22

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

Electronically Signed | 07/28/2022

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
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 689	Continued From page 1 accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow the care plan, failed to complete comprehensive fall assessments for causal factors/root cause and identify care plans were not followed for 2 of 3 residents (R8, R5). The facility's failures resulted in actual harm to R8 when the first fall resulted in head lacerations that required treatment in the emergency room. In addition, the facility failed to ensure a comprehensive fall assessment was completed to ensure safe transfer for R5 following a fall. Findings include: R8's face sheet identified R8 had diagnoses of chronic hypotension, osteoporosis in multiple sites, displaced interochanteric fracture of the left femur and presence of left artificial shoulder joint. R8's discharge, minimum data set (MDS) assessment, dated 5/23/22, identified that R8 was cognitive and had 1 fall with an injury. R8's significant change, MDS assessment, dated 6/2/22, indicated R8's cognition was intact. The MDS identified R8 did not walk, required extensive assist of two staff with bed mobility and was totally dependent on two staff with transfers. R8 had a functional limitation in range of motion in both of his upper extremities and used a wheelchair for mobility. R8's pain management identified that R8 had been on a scheduled pain medication, received PRN (as needed) medications and non-medication interventions for pain, his pain was occasional and moderate and	F 689	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R#8 is no longer a resident of the facility. R#5 investigation and documentation related to the fall event that occurred on 6/27/22 was reviewed and updated by clinical IDT on 7/26/2022 to include newly discovered information and validate an accurate reflection of the fall event including root cause analysis, contributing factors, and subsequent interventions to decrease risk for further falls/accidents. R#5 was reviewed by IDT on 7/27/2022 including completion of bladder assessment, fall risk assessment, and care plan review and revision based on information obtained from assessments. Additionally, the resident was measured to validate proper sling size is in use for surface transfers including toileting. Expanding the group, IDT completed a review of current residents that have the potential to be affected, determining all current residents of the facility were at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 689	Continued From page 2 made it hard to sleep at night. Further identified that R8 had a fall in the last month prior to admit. R8's care plan dated 8/9/21, identified R8 was at risk for falls related to impaired mobility and history of falls; intervention included call light within reach at all times. R8's also identified R8 had a problem with pain due to left shoulder replacement, history of left femur fracture, and impaired mobility; interventions included when R8 expresses pain to offer repositioning, rest. Cold therapy and prn analgesics and to monitor pain every shift. Additionally, R8 required 1-2 staff for assist with bed mobility and assist of 2 with mechanical stand for transfers and did not walk. Review of R8's record identified R8 had falls on 5/15/22 and 6/27/22. During an interview on 7/7/22 at 8:04 a.m. family member (FM)-A stated R8 had told them the night he fell on 5/15/22, he had put on his call light at 3:00 a.m. to get out of bed because his back was hurting. The nursing assistant told him she would be back in a while as they did not have time to get him out of bed. FM-A stated since no one would help him he tried to get himself out of bed and fell to the floor. FM-A stated R8 had to be transferred to the hospital for lacerations. FM-A indicated facility staff were slow at responding to the call lights during the night. During an interview on 7/7/22 at 8:20 a.m. R8 stated he has had back pain for a long time, even before coming to the facility. R8 explained when he was at home he would have back pain during the night; R8 stated he would get out of bed and move around a little bit and go to his recliner. R8 stated he remembered the fall on 5/15/22, stated	F 689	potential risk based on review of resident fall risk observations, fall risk scores, level of assistance needed for transfers and previous fall history. Each resident's care planned fall interventions were reviewed and updated as needed by IDT. Reviews of fall interventions for current residents were completed by 8/4/2022. CNA involved in transfer of resident on 6/27/22 was re-educated by DON on 7/13/2022 in relation to requirement of 2 assist for pivot transfer per resident plan of care as well as with mechanical lift device and following plan of care for all surface transfers and cares. LPN that completed fall event was re-educated by DON on 7/27/2022 in relation to obtaining information from residents and staff post fall in order to assist in determining circumstances of fall as well as root cause in order to ensure accuracy of assessments and plan of care. Clinical leadership team was educated by Regional Director of Clinical Services on 7/19/22 in relation to fall management protocols including completion of investigation and assessments post incident in order to determine contributing factors, root cause, and appropriate interventions to decrease risk to residents. Nursing direct care staff of the facility were educated by DON/Clinical Leadership in relation to fall management protocols including following individual	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 689	Continued From page 3 he had put on his call light around 3:00 a.m. and wanted to get out of bed because his back was hurting. R8 stated a white female responded and told him she was too busy to get him up, would have to wait, and would go tell the nurse his back was hurting. R8 stated he got the Tylenol, did not recall the time, but continued to have back pain. R8 then stated he tried to get out of bed himself because of the pain and fell onto the floor. R8 indicated he does not recall someone sitting him up on the side of the bed. R8 stated since the fall he has had some right shoulder pain as well. R8 indicated he had fallen a second time, didn't remember all the details, but remembered he wanted to sit up because his back was hurting and he had put his call light on. R8's call light log reviewed for 5/15/22, and indicated he had turned his call light on at the following times: -2:46 a.m. and took staff 19 minutes and 57 seconds to respond and were in his room for 15 seconds. -4:28 a.m. and took staff 6 minutes and 7 seconds to respond and were in his room for 9 minutes and 46 seconds. R8's progress note dated 5/15/22, indicated that R8 had complained of lower back ache at 3:40 a.m. and requested some Tylenol, which was somewhat effective. R8's record lacked evidence non-pharmacological interventions were attempted or offered in accordance with the care plan and did not identify what pain control measures were taken after it was identified the Tylenol was somewhat effective. R8's Event Report dated, 5/15/22, at 5:15 a.m. indicated R8 had an unwitnessed fall from his bed	F 689	resident plan of care for transfers, investigation of falls/accidents, interviewing of staff/residents post incident, completion of assessments and identifying contributing factors in order for IDT to determine root cause and appropriate interventions to decrease risk of further falls/accidents/hazards for residents. This education started during survey on 7/7/2022 and will be completed by 8/4/2022. Audits of fall events including investigation and accuracy of assessments will be audited by Clinical RN Managers to validate determination of risk factors, contributing factors, root cause, appropriateness of interventions, and care plan revisions. Audits will be completed 3x weekly x8 weeks, then 2x weekly x2 weeks, then as needed to validate compliance. Audits will be reviewed by DON/designee weekly to validate ongoing and sustained compliance with Plan of Corrections and facility protocols. Audits will be brought through QAPI committee for review and further recommendations. Audits will be discontinued only upon recommendation of QAPI committee once sustained compliance has been determined.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 689	Continued From page 4 (did not identify what time the fall occurred), was observed lying on his right side with his right arm tucked underneath him and a pool of blood under his head. When asked what happened R8 stated that he was sitting on the edge of the bed and had tried to reach for his TV remote so he could then lay back down because his back still hurt, then suddenly he slipped out onto the floor hitting his head on the tray table. R8 had complained of lower back pain from earlier in the night. R8 received two lacerations on his forehead above his right eye and steri strips were applied. R8 complained of being nauseous. When blood was being scrubbed out of his hair R8 vomited clear fluids, MD was notified and R8 was sent to the ED for a CT scan for possible increasing ICP (intracranial pressure). Immediate intervention was to offer to get up at 4:00 a.m. if not already awake. R8's ED Provider Notes, dated 5/15/22, at 6:29 a.m., indicated R8 had a diagnosis of chronic lumbar spinal stenosis and osteoporosis and was being assessed from a fall where R8 stated he was sitting on the side of the bed because of his chronic low back pain where he was leaning on one of the tables and fell hitting the right side of his head on the table. R8 sustained some abrasions and lacerations to the right frontal area, has complaints of neck pain, right shoulder pain and tingling from his elbows to his fingers bilaterally. Noted to have 2 right frontal lacerations that are 3 cm in length with surrounding abrasions and bruising. R8 had labs completed, CT of cervical spine and head without IV contrast and received laceration repaired with Dermabond (surgical skin glue). R8's record lacked a comprehensive fall	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 689	Continued From page 5 assessment; the post fall assessment dated 5/17/22 identified the intervention was to offer to get R8 up at 4:00 a.m. if not already awake even though R8's care plan directed staff to reposition R8 if he were having pain. R8's Event Report, dated 6/27/22, at 4:08 a.m. indicated R8 had an unwitnessed fall from bed and was found on his buttocks next to bed (did not identify what time the fall occurred). R8 stated his call light had fallen to the floor and when he kicked his legs over the side of the bed to get into a sitting position, his pressure reducing boots he was wearing slid him to the floor. Immediate intervention that was placed was to knot the call light to the side rail of bed to prevent it from falling on the floor. R8's call light log reviewed for 6/27/22 and indicated he had turned his call light on at the following times: -12:35 a.m. and took staff 3 minutes and 34 seconds to respond and did not identify any time spent in his room. -3:15 a.m. and took staff 10 minutes and 39 seconds to respond and identified staff spent 25 minutes and 42 seconds in his room. R8's record lacked a comprehensive fall assessment. During an observation on 7/7/22 at 8:02 a.m. R8 sat in his recliner. R8's bed did not have a side rail and the clip to the call light was broken. FM-A stated R8's side rail was removed from his bed 4 days ago, the facility told us the state would not allow side rails because it was against regulation. R8 stated he used the side rail for re-positioning. At 8:21 a.m. maintenance staff entered the room	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 689	Continued From page 6 and put on new bed rail. During an interview on 7/7/22, at 8:04 a.m. licensed practical nurse (LPN)-A indicated she had been R8's nurse the night of 5/15/22. LPN-A was not able to articulate R8's back pain history and stated R8 only had shoulder pain. LPN-A indicated she administered Tylenol at 3:40 a.m., had not attempted non-pharmacological interventions which included repositioning, and at 4:15 a.m. she had went to re-evaluate the effectiveness of the Tylenol. LPN-A stated medication was somewhat effective, so she had instructed the NA's to get R8 out of bed. LPN-A first indicated R8 had been reaching for the remote and slipped on the floor, however then stated R8 had reported to her that he had requested to get out of bed and the NA's had not gotten him up. LPN-A indicated as part of the fall investigation she had not tried to determine how R8 sat up on the side of the bed independently, had not reviewed the call light log, and had not interviewed NA's to ascertain additional causal factors. LPN-A indicated she had revised the care plan without completing a comprehensive fall assessment and the intervention of offering him to get up at 4:00 a.m. came from had the NA's gotten R8 out of bed when he requested the fall would not have occurred. LPN-A stated on 6/27/22 she had also been R8's nurse, R8 had put on his call and when we responded to the call light around 4:00 a.m. he had been on the floor. When asked what R8 had put his call light on for, LPN-A stated an unawareness. LPN-A indicated the root cause was that the call light had fallen on the floor but did not know how the call light got there or if the call light had been secured and within reach prior to the fall. LPN-A indicated she had not interviewed staff for additional causal	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 689	Continued From page 7 factors to ensure appropriate interventions in place to mitigate further risk. During an interview on 7/7/22 at 8:41 a.m. NA-H stated a familiarity with R8. NA-H indicated during the night R8 had pain in his left shoulder, back, right hand/wrist. NA-H indicated warm/cold packs and repositioning were R8's interventions to relieve pain. NA-H stated R8 was an early riser, he was always up at 3:00 a.m., and always wanted to get out of bed because of back pain; that had been his routine since admission last year. NA-H stated he knew he wouldn't have tried to get out of bed himself but thought he had enough upper body strength to pull himself up onto the edge of the bed. During an interview on 7/7/22, at 1:00 p.m. NA-G stated R8 could independently make small position changes in bed however required physical assist of two staff to sit on the edge of the bed. NA-G stated there is no possible way R8 could independently get to a sitting position, someone would have to assist him. NA-G stated she had worked overnight shift on 5/15/22, R8 had put on his call light around 3:00 a.m. and only wanted Tylenol, so she went and told LPN-A. NA-G indicated at about 3:45 right after the Tylenol was given, R8 requested to get out of bed however wanted to give Tylenol time to work. NA-G stated she had not gone back in the room until when she had found him on the floor. NA-G indicated an unawareness of how R8 would have been sitting on the side of the bed according to the fall report and was not aware if another staff member had assisted him. NA-A stated R8 typically got out of bed around 4:00 a.m. and that was his norm., NA-G also indicated R8 typically had back pain at night, but it was usually around	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 689	Continued From page 8 4:00-4:30 not 3:00 a.m. R5 R5's admission Minimum Data Set (MDS), dated 5/3/22, indicated R5 had moderate cognitive impairment and had diagnoses that included cerebral infarction with hemiplegia and hemiparesis, ataxia (loss of coordination of voluntary muscle movements) Alzheimer's disease, stress incontinence. R5 required extensive one assist from staff for dressing and personal hygiene and extensive two assist for bed mobility, transfer, and toilet use. The MDS indicated R5 did not reject/refuse care or other behaviors. . R5's admission fall risk assessment dated 5/3/22, identified R5 was a fall risk, had a history of falls, had functional range of motion limitation of one upper extremity and one lower extremity of the left side related to stroke, and was steady during transfers. R5's care plan dated 4/29/22, identified R5 was not able to walk and directed R5 was a pivot transfer with assist of two staff in the morning except to recliner, which was assist of two with mechanical lift, and in the evening R5 was a assist of two with mechanical lift. The care plan did not identify what type of mechanical lift nor a sling/harness size. R5's care plan also identified R5 was at risk for falls related to cognitive deficit, impaired mobility, and use of psychotropic medications. The fall care plan dated 4/29/22 included the intervention of ensure call light is within reach. R5's fall incident report dated 6/27/22, at 9:29 a.m. indicated R5 was lowered to the floor in her	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 689	Continued From page 9 bathroom after her knees "gave out" while transferring to the toilet. R5 did not sustain injuries. Immediate intervention was R5 downgraded from pivot transfer with two staff to mechanical stand with two assist. R5's corresponding progress note indicated the fall occurred at 9:25 a.m. when two staff pivot transferred R5 off the toilet. R5's record identified R5 had an assisted fall to the floor on 6/27/22 at 9:29 a.m. Interview with facility staff and review the facility's video surveillance did not correlate with the information documented in R5's progress note related to the fall. Video surveillance was watched with facility social worker; video identified only one NA was in the room when R5 had the fall, the NA left the room and shortly thereafter came back to R5's room with another NA. During an interview on 7/7/22, at 10:18 a.m. LPN-A stated she was R5's nurse and completed the incident report. LPN-A stated she had not interviewed the staff involved and assumed two staff were present at the time because when she got to R5's room, there were two aides in the room. LPN-A was not aware NA-B had not followed R5's care plan and transferred R5 by herself. LPN-A stated after the incident she had downgraded R5 to a mechanical standing lift without completing a comprehensive lift assessment prior to changing the care plan and could not articulate what a safe lift assessment consisted of. LPN-A stated she had not consulted with physical or occupation therapy and was not aware that therapy had deemed the standing lift unsafe for R5 to use because of R5's muscle weakness.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 689	Continued From page 10 During an interview on 7/7/22 at 12:30 p.m. NA-C stated she had worked on 6/27/22, NA-C stated NA-B came to get her from the unit she was working on after she had transferred R5 to the toilet by herself. NA-C stated R5 was supposed to use two assist to pivot transfer because her knees get a little wobbly and can't tolerate standing a long time. NA-C indicated R5 was not safe to transfer with one. During an interview on 7/7/22, at 11:25 a.m. occupational therapist (OT) stated she had not been aware R5 had to be lowered to the floor and was not aware nursing had changed R5 to a mechanical standing lift. OT stated nursing should have downgraded R5 to a full body lift because R5 could not tolerate the standing lift related to her ataxia. OT indicated therapy had already determined a standing lift would not have been appropriate for her to use. R5's record identified R5 had another fall on 7/4/22, indicated R5's fall was related to toileting. R5's record lacked a comprehensive fall assessment that identified causal factors/root cause and did not include an evaluation of the effectiveness or appropriateness of R5's toileting program. The fall records indicated R5 had an unwitnessed fall without injury on 7/4/22 at 7:30 p.m. when she had attempted to use her bathroom. R5's progress note dated 7/4/22, included "Resident had attempted to get up out of her wheelchair to use the toilet." Resident's legs could not hold her up and she sat down on the floor. Immediate intervention was to offer R5 toileting immediately after husband leaves room and then assist resident into bed. R5's bladder/bowel care plan dated 4/29/22 (prior	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 689	Continued From page 11 to the fall) identified R5's toileting program was every two to three hours and as needed. Although the R5's record included a bowel/bladder assessment, the assessment was not comprehensive; the assessment did not identify what type of bladder incontinence R5 had or evaluation of R5's toileting routines. During an observation and interview on 7/6/22, at 7:34 a.m. NA-A and NA-B observed performing toileting cares and assisting resident up to wheelchair prior to breakfast. R5 observed heavily incontinent of urine which had soaked through her brief and linens and onto mattress down to her knees. NA-B offered R5 to use bedpan. R5 stated, "I'd rather use the toilet." NA-B stated R5 was unable to use the toilet due to a physical therapy recommendation and wanted her to get stronger before using a toilet. R5 voided a large amount of urine in bedpan. A mechanical full body lift was used to transfer R5 from bed to wheelchair. When interviewed on 7/6/22, at 10:28 a.m. R5 stated she would rather use the bathroom toilet; however, "staff have told me I am unable to use the toilet as they fear I will fall." During an interview on 7/7/22, at 10:18 a.m. LPN-A reviewed R5's record and indicated she had not interviewed nursing staff after the fall and was not aware if R5's toileting plan had been followed. LPN-A further indicated the intervention of toileting R5 after her husband left was implemented without a full investigation and stated a comprehensive bowel/bladder assessment was not completed after the fall. LPN-A stated she would have expected NA's to follow the toileting care plan.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 689	Continued From page 12 On 7/7/22, at 3:09 p.m. director of nursing (DON), social worker (LSW), and regional nurse executive director (RNED) were interviewed. DON stated the expectation the nurse would complete the fall assessment, determine probable root cause, and implement immediate interventions. DON indicated then the interdisciplinary team reviews the fall and determines if the intervention was appropriate and implement additional interventions if necessary. DON stated she expected the nurse(s) to have a fall huddle after the fall to collect information, review the resident record in order to collect pertinent information and that information documented. RNED indicated the facility currently was not using safe mechanical lift transfer assessments and would get those implemented immediately. Facility policy Integrated Fall Management dated 5/6/2021 included Residents are assessed for their risk of falls upon admission, significant change and quarterly thereafter. Residents with risk for falling will have interventions implemented through the resident centered care plan. When a resident experiences a fall, a licensed nurse assesses the residents condition, provides care for, safety and comfort. Post fall Procedure included the following: 7. When a resident falls the licensed nurse is notified. The nurse completes an assessment of the resident's condition including an interview, if possible, completion of vital signs and a body assessment. 8. The medical provider is notified of the fall and resident condition. Orders, if given, are implemented. 9. The resident's representative (as applicable) is	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 689	Continued From page 13 notified of the fall and the resident's condition. 10. The DON and Administrator or their designees are notified of the fall. 11. The environment of the fall is evaluated for possible contributing factors and addressed. 12. The interdisciplinary team reviews the fall and care plan changes and may, if needed, implement additional interventions. 13. Additional professionals may be contacted to provide assessment and/or interventions regarding fall risk and prevention, including but not limited to, attending physician/provider, pharmacist, physical therapist, occupational therapist, and speech therapist. 14. Documentation of the above items is completed.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon	F 690		8/4/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 690	Continued From page 14 as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and document review, the facility failed to complete a comprehensive assessment for individualized toileting program and provide toileting assistance that was dignified, per resident choice, and to prevent urinary tract infections and worsening bladder incontinence to the extent possible for 1 of 1 residents (R5) who was reviewed for falls related to toileting. Findings include: R5's admission Minimum Data Set (MDS), dated 5/3/22, included moderate cognitive impairment with diagnosis including cerebral infarction with hemiplegia and hemiparesis, Alzheimer's disease, dementia, anxiety, stress incontinence, and ataxia. R5 required extensive one assist from staff for dressing and personal hygiene and extensive two assist for bed mobility, transfer, and toilet use. No psychosis, behaviors, rejection of care, or wandering noted on MDS.	F 690	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. Resident #5 was reassessed by clinical RN Manager on 7/19/22. Based on assessment, care plan was updated to reflect current interventions to promote increased continence with staff assistance as well as resident's method of communicating toileting needs. Current residents of the facility requiring assistance of staff for toileting were reviewed by nursing management to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 690	Continued From page 15 R5's toileting care plan dated 4/29/22, directed staff to toilet every two to three hours and as needed to help skin remain free from breakdown. The care plan also directed staff to respect her dignity. The care plan also included R5 required assist of two to get toileting needs addressed. R5 used briefs and the toilet. R5's admission bladder assessment dated 5/3/22, licensed practical nurse (LPN)-A documented R5 was always incontinent of bladder and wears briefs. R5 required staff assist with brief management and hygiene. Staff offer toileting assist every two to three hours and as needed. R5 at risk for incontinence due to diagnosis, medications, and needing assistance with activities of daily living (ADL's) and transferring. R5 denied any bladder issues or difficulties voiding. R5's nursing assistant (NA) daily care card, indicated R5 was assist of two with mechanical stand on dayshift and assist of two with full body mechanical lift on evening and night shift with toileting frequency upon demand. However, therapy orders on R5's closet door directed R5 was a pivot transfer with two staff during the day and full body mechanical lift in the evening. R5's progress note dated 7/5/22, at 4:10 p.m. indicated R5 used assist of two for toileting hygiene, used call light, and requested to be assisted to toilet. During an observation on 7/6/22, at 7:16 a.m. R5 was asleep in bed with door closed. A stale urine odor was present inside room.	F 690	validate accuracy of assessments and resident's current status related to incontinence and assistance to be provided. Direct care nursing staff were educated by nursing management in relation to bladder assessments, toileting needs, and appropriate interventions to promote continence and safety during toileting assistance. This education started during survey on 7/7/2022 and will be completed by 8/4/2022. Audits of bladder assessments and care planned interventions completed and put in place by the clinical managers will be performed by IDT to validate accuracy of the assessments and care plan interventions ensuring a current reflection of resident status related to continence status, resident choice and level of assistance to be provided. Bladder assessment audits will be completed 3x weekly x2 weeks, 2x weekly x2 weeks, then as needed to validate ongoing compliance. DON/designee will review audits weekly to validate compliance with plan of correction. Audits will be brought through QAPI committee for review and further recommendations. Audits will be discontinued only upon recommendation of QAPI committee once sustained compliance has been determined. The achieved compliance will be maintained by quarterly IDT reviews that will include an assessment of resident's bladder assessment, continence status, resident choice and level of assistance provided by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 690	Continued From page 16 During an observation and interview on 7/6/22, at 7:34 a.m. NA-A and NA-B observed performing toileting cares and assisting resident up to wheelchair prior to breakfast. R5 observed heavily incontinent of urine which had soaked through her brief and linens and onto mattress down to her knees. NA-B offered R5 to use bedpan. R5 stated, "I'd rather use the toilet." NA-B stated R5 was unable to use the toilet due to a physical therapy recommendation and wanted her to get stronger before using a toilet. R5 voided a large amount of urine in bedpan. A mechanical lift was used to transfer R5 from bed to wheelchair. When interviewed on 7/6/22, at 10:28 a.m. R5 stated she would rather use the bathroom toilet; however, "staff have told me I am unable to use the toilet as they fear I will fall." When interviewed on 7/6/22, at 10:36 a.m. NA-C stated facility has a toileting sling for mechanical lifts to transfer resident's to toilet. NA-C stated R5 transferred with mechanical lift and two assist. NA-C stated R5 was incontinent at all times. When interviewed on 7/6/22, at 1:58 p.m. physical therapist (PT)-A stated R5 was upgraded on 6/21/22 to stand and pivot with two assist during day shift and use mechanical lift with two assist for evening/night shift. PT-A stated therapy would never tell nursing to not toilet a resident in the bathroom and use a bedpan as that inhibits the rehabilitation process. When interviewed on 7/6/22, at 2:08 p.m. LPN-A stated she expected NA's to find a toileting sling if R5 wanted to use the toilet; however, LPN-A stated R5 was always incontinent and used her	F 690	staff, utilizing resident and staff interviews and point of care charting reviews.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 690	Continued From page 17 brief for toileting. When interviewed on 7/6/22, at 4:51 p.m. director of nursing stated her expectation for nursing staff to assist R5 to the toilet when requested as only allowing R5 to use a bedpan would inhibit resident from meeting her rehabilitation goals and treatment plan. DON stated toileting is always the best option to reinstate a bowel and bladder regimen for residents. When interviewed on 7/7/22, at 8:41 a.m. NA-D stated R5 was continent and alerted staff to when she needed to use the toilet. NA-D stated R5 used a mechanical stand and two assist. NA-D stated R5 was on a toileting two hour round and staff are notified on the call light system when the time period was up. When interviewed on 7/7/22, at 10:18 a.m. LPN-A reviewed R5's record and indicated R5's record did not include an assessment that evaluated R5's toileting patterns and routines, an incontinence diary had not been completed. LPN-A indicated an unawareness R5 had the ability to know when she had to use the toilet and had not completed a comprehensive assessment to determine the extent or reason for R5's incontinence. The policy titled Activities of Daily Living (ADL) dated June 2021, indicated to provide residents with care, treatment, and services appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). -Residents unable to carry out ADL's independently will receive the services necessary to maintain good nutrition, grooming, personal hygiene, elimination, communication, and	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	213 PIONEER ROAD RED WING, MN 55066

(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 690	Continued From page 18 mobility. -Care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including support and assistance with: hygiene (bathing, dressing, grooming, and oral care), mobility (transfer and ambulation, including walking), elimination (toileting), dining (meals and snacks, and communication (speech, language, and any functional communication systems). -Interventions to improve and/or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals, and recognized standards of practice. -The resident's response to interventions will be documented, monitored, evaluated, and revised as appropriate.	F 690		