DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 15, 2024

Administrator
Villa St Vincent
516 Walsh Street
Crookston, MN 56716

RE: CCN: 245484
Cycle Start Date: April 2, 2024

Dear Administrator:

On May 7, 2024, 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.

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 15, 2024

Administrator
Villa St Vincent
516 Walsh Street
Crookston, MN 56716

Re: Reinspection Results
Event ID: BKRW12

Dear Administrator:

On May 7, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 2, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 12, 2024

Administrator
Villa St. Vincent
516 Walsh Street
Crookston, MN 56716

RE: CCN: 245484
Cycle Start Date: April 2, 2024

Dear Administrator:

On April 2, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- 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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 July 2, 2024 (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 October 2, 2024 (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
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
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
	245484	A. BUILDING _____ B. WING _____	C 04/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 3/28/24 through 3/29/24 and 4/2/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54842357C (MN101850) H54842572C (MN101479) H54842571C (MN101758) H54842711C (MN102018) H54842573C (MN101708) with a deficiency 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=D	. 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	F 689		5/1/24

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

Electronically Signed | 04/19/2024

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

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F 689	Continued From page 1 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop and implement interventions to ensure adequate supervision for 1 of 1 residents (R5) reviewed who had multiple incidents of unsafe behavior related to marijuana use. Findings include: R5's face sheet identified diagnosis that included Schizo-affective disorder, dementia without behaviors, mood disturbance and anxiety. R5's quarterly Minimum Data Set (MDS) dated 3/15/24, identified moderate cognitive impairment. The MDS indicated R5 had hallucinations and did not display any behaviors. The MDS indicated R5 was independent with mobility, transfers and ambulation and had sustained two or more falls since the previous assessment. R5's Fall Risk and Functional Limitation Observation dated 3/15/24, identified intermittent confusion and use of assistive devices. The observation identified the use of marijuana. The observation indicated both physical and cognitive limitations increased R5's risk for falls and indicated she had three falls since the previous observation period. The observation identified the use of recreational marijuana but lacked assessment related to how the marijuana use affected R5's physical functioning and falls. R5's care plan dated 3/18/24, indicated she	F 689	1. Corrective Action for the residents found to have been affected by the alleged deficient practice: " Identified our deficient practice to be related to the process of assessing and supervising resident R5 as they utilize marijuana in the facility smoke shack. We have updated the facility smoking observation, this will be completed on all active smokers currently residing at the facility. R5□s care plan has been revised to reflect the facilities interventions to provide a safe environment for R5 when smoking and her substance use disorder. R5□s safety contract has been updated to include the following: the agreement to use a Resident Guard to help que the resident to alert staff of activities. The resident has agreed to turn the lockbox key over to nursing after use. R5 is in agreement to the updated safety contract provided. R5 has also agreed to turn over the lockbox key to staff to allow staff to track use, evaluate cognitive level and extent of effects present. An order set has been developed to que staff to perform this task Q shift. When the resident is visibly impaired staff will discourage use of marijuana while providing other options as well as education. 2. Other residents identified as having potential to be affected by the same alleged deficient practice: " All residents that request to utilize	

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F 689	Continued From page 2 smoked recreational marijuana. The care plan indicated R5 had a smoking contract in place and would practice safe smoking habits. The care plan directed staff to remind R5 she was not to be unaccompanied when ambulating outside the facility due to her choice of marijuana use but indicated R5 was not always compliant. The care plan further identified a risk for falls. R5's Marijuana Use Contract updated 3/20/24, indicated nursing staff was able to restrict access to the smoking area outside if R5 appeared medically unstable or too intoxicated to safely perform activities of daily living including but not limited to steady walking, keeping eyes open, dressing appropriately, able to communicate and able to pass a safe smoking evaluation. The contract indicated R5 would limit her marijuana use to three times per day, two one-hitters (used to smoke marijuana) between the hours of 6:00 a.m. and 2:00 a.m. R5's facility Progress Notes identified the following: 3/6/24, R5 attempted to go out to the smoke shack and writer denied her due to R5's eyes being barely open. Later, around midnight, NA spotted her on the camera in the smoke shack. 3/9/24, at approximately 1:00 a.m. R5 wanted to go out to the smoke shack. Writer told her no as her eyes were barely open and she was wearing only her bra with a winter coat unzipped. R5 went back to her room and returned about 30 minutes later with a shirt on but no coat and went out to smoke. 3/13/24, R5 was awake all night going to the	F 689	smoking products while residing @ BLC-Crookston will partake in a safe smoking evaluation performed by an RN to assess their ability to do so safely. Once they have been deemed safe, they are able to utilize the smoke shack independently as they wish. Therefor all resident utilizing smoking products have the potential to be affected. The smoking observation has been update and will be completed with all residents that utilize smoking products by 5/1/24 to include visualization of how they go to & from the smoke shack, safety with all aspects of smoking. Lighting, handling of the ashes and extinguishing the cigarette. 3. Measures put into place/changes made to ensure the alleged deficient practice will not recur: " We have reviewed the Resident smoking and substance use policies. The smoking policy has been updated to include the use of cannabis. " The residents safety contract has been updated to include the following: the agreement to use a Resident Guard to help que the resident to alert staff of activities. The resident has agreed to turn the lockbox key over to nursing after use. " The resident will utilize the Resident Guard to que her to alert staff before going out to the smoke shack. The resident has also agreed to turn over the lockbox key to staff to allow staff to track use, evaluate cognitive level and extent of effects present. An order set has been developed to que staff to perform this task t/o the shift, Q shift. When the resident is	

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F 689	Continued From page 3 smoke shack, eyes barely open and sometimes going when staff were with other residents. 3/15/24, R5 went to nurses station, gait somewhat unsteady and eyes closed. When R5 opened her eyes they were red and R5 had slurred speech. Writer asked R5 not to go to the smoke shack and R5 stated she had just woken up. R5 had been to the smoke shack at least 4-5 times. 3/17/24, At approximately 12:15 a.m. R5 was found on the floor by staff. R5 had just gone out to smoke and smelled like marijuana. 3/18/24, R5 was observed on the floor watching a movie and asked for assistance back to bed. Writer asked her how she got on the floor and R5 stated, "I was waiting for the floor to come to me and it took so long so I came to the floor" and said "I had important things to do with the floor." It was noted 20 minutes before, R5 had been in the smoke shack smoking her marijuana. When asked if she was okay R5 stated, "yes, I'm just high." 3/18/24, IDT discussed falls. R5 had fallen twice and had been smoking marijuana prior to each fall. Interventions to revisit contract and provide education. 3/18/24, Another resident reported that R5 was "sleepwalking" and went into another residents room around 4:00 a.m. 3/29/24, R5 was noted to come back inside facility with no jacket and her walker in the smoking area. 3/29/24, R5 was noted to be in another residents room attempting to remove the toilet seat riser.	F 689	visibly impaired, staff will discourage use of marijuana while providing other options as well as education. "Education will be provided to all staff of the Resident smoking and substance use policies, the processes, procedures involved and safety contract on or before April 30th. A copy of the safety contract will be available at the 240 station for all staff to review as needed to ensure understanding & compliance. 4. How the facility will monitor its corrective actions to ensure the alleged deficient practice will not recur: "The DON or their designee will audit the process for accuracy and compliance weekly for the next 90 days with plan to decrease once compliance sustained. "The DON or their designee will report to the quality assurance committee quarterly, continued audits will be determined based on compliance and input from the facilities quality committee. 5. Date alleged deficiencies will be corrected: "May 1,2024	

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F 689	Continued From page 4 Staff assisted R5 back to her room. R5 stated she was going out to smoke and was not able to be redirected. During observation on 3/28/24 at 2:53 a.m., R5 ambulated independently from her room to the smoke shack outside wearing a long shirt, jacket and shoes. R5 was not wearing any pants and her shirt only reached to just below her buttocks. No staff were observed in the vicinity. R5 could be seen on the camera at the nurses station in the smoking shack. R5 left the smoking area and returned to the building at 3:02 p.m. At 4:03 p.m. R5 again ambulated out to the smoking area. R5 was wearing pants at this time. R5 was seen on the camera smoking a cigarette and returned to the building at 4:07 p.m. Again no staff was in the area. At 4:32 p.m. R5 was again observed on camera in the smoke shack. R5 had a locked box she placed under the seat of her walker. At 4:36 p.m. R5 entered the building and returned to her room. At 5:04 p.m. R5 left her room and ambulated out to the smoking area. R5 was seen on the camera as she entered to smoking area. R5 removed a locked metal box from under the seat of her walker and lit and smoked a "one hitter." At 5:09 p.m. R5 returned the box under the seat of her walker, exited the shack and returned to her room. During the observations, no staff were in the vicinity of the nurses station. During interview on 3/29/24 at 9:36 a.m., NA-A stated she did not usually work on the unit but said she was aware R5 had falls. NA-A said fall interventions were listed on the care sheets. NA-A said she was aware R5 smoked marijuana and said she was allotted a certain amount each day but was not sure how much or how often. NA-A said she was not in charge of monitoring	F 689		

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F 689	Continued From page 5 when R5 went outside. During interview on 3/29/24 at 9:45 a.m., NA-B stated she was a little bit familiar with R5. NA-B said she was aware R5 was allowed to smoke marijuana and thought R5 had to sign out. NA-B said she did not know about any of R5's falls. During interview on 3/29/24 at 9:55 a.m., NA-C stated he was aware R5 was a fall risk and said fall interventions were on the care sheet. NA-C said R5 had a plan for her marijuana use and said one time he saw the paper (contract). NA-C said if R5 wanted to smoke she had to ask whoever was at the desk and had to sign out on a sign out sheet. During interview on 3/29/24 at 10:06 a.m., registered nurse (RN)-B stated R5 had not fallen on the day shift but had a recent fall on the p.m. to overnight shift. RN-B said fall interventions included proper footwear and said that was the only intervention she was aware of. RN-B stated R5 smoked marijuana and said she did that on her own. RN-B said R5 had her own stuff, managed it on her own and did not tell staff when she was using it. RN-B said if she saw R5 going outside she would assess if she saw signs of her being high, like if she was able to talk to her, still standing and dressed appropriately. RN-B said there were times when she had to remind R5 to dress appropriately. RN-B further stated she had not received any direction to monitor when or what R5 was smoking. During interview on 3/29/24 at 10:15 a.m., trained medication aide (TMA)-A stated she was not sure what R5's fall interventions were but said she was aware R5 had fallen. TMA-A stated she was	F 689		

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F 689	Continued From page 6	F 689		

aware R5 smoked marijuana and said she believed there was a contract in place that placed restrictions on the times R5 could smoke. TMA-A stated R5 started using marijuana at the facility when it became legal and said she was not aware of any falls when R5 was outside or when she was "high."

During interview on 3/29/24 at 10:21 a.m., R5 stated she had been trying to do what the facility asked, staying away from other people while smoking marijuana. R5 said they check to make sure she was not stoned enough that she fell and said "I've done that before." R5 said she doesn't have to check out. R5 said they told her she could smoke marijuana three times per day but said nobody monitors it. R5 said she had been smoking marijuana at the facility for a little over a year but had told the facility when it became legal. When asked how many of her falls occurred when she was under the influence of marijuana, R5 stated 50%.

During interview on 3/29/24 at 10:27 a.m., NA-D stated she only worked on the unit about once a month but was familiar with R5. In regard to R5's marijuana use, NA-D said "I feel like she is kind of overdoing it a little bit." NA-D said R5 couldn't keep her eyes open and said she acts kind of "zombie-ish." NA-D said she was not aware of any restrictions on R5's marijuana use.

On 3/29/24 at 10:56 a.m., registered nurse (RN)-A and licensed social worker (LSW)-A were interviewed. RN-A stated a lot of R5's falls were due to non-compliance with footwear. RN-A said maintenance had replaced the wheels on R5's walker because they were not locking and said a lot of education was given to R5. RN-A reviewed

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F 689	Continued From page 7 R5's medical record and said she had not fallen since January of 2024. When questioned about the most recent falls RN-A confirmed R5 had fallen in March 2024, and said following that fall she and LSW-A had talked to her about her marijuana use safety contract. RN-A stated R5 had denied the marijuana was causing her falls. In regard to the smoking assessment that was completed due to R5's increase in falls, RN-A stated it was completed to determine if R5 was still safe to smoke. RN-A acknowledged the assessment did not address R5's ability to safely get to the smoking area. RN-A stated if a resident who smoked cigarettes was falling they would assess if they were safe to get to the smoking area and return. LSW-A stated usually at night staff would tell R5 she was not safe to go outside. LSW-A said from what she had read, R5 was able to sign herself out even if she was impaired. LSW-A said the charge nurse would advise R5 not to go outside if staff felt like she was not safe. LSW-A stated the charge nurses knew they were responsible to monitor R5. When asked how it was communicated to the charge nurses, RN-A stated "they know." LSW-A said R5 agreed as part of her marijuana use contract to only smoke it 2-3 times per day but said all staff could do was kind of watch to see how many times R5 was going outside. LSW-A said the facility has been aware of R5's marijuana use since August of 2024. During interview on 4/2/24 at 11:58 a.m., the director of nursing (DON) stated when R5 began smoking marijuana at the facility she would go outside and sit in an area that was not the designated smoking area. The DON stated the facility did not have a marijuana use policy and said LSW-A and RN-A had many conversations	F 689		

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VILLA ST VINCENT	516 WALSH STREET CROOKSTON, MN 56716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 8 with R5 to come up with a compromise. The DON said R5 had proposed the idea about using the one hitter three times a day but after she agreed she decided it wasn't enough. The DON stated due to the falls, the facility encouraged her to alert staff or to sign out so someone could monitor the amount of time she was out. The DON said if staff were aware and R5 appeared to be under the influence they tried to watch the cameras but said they did not have anyone designated to supervise R5. Facility Integrated Fall Management policy dated 8/24/17, indicated fall risk assessment, identification and implementation of appropriate interventions were necessary to maintain resident safety. The policy indicated care planned interventions were based on the finding of the fall risk assessment. The policy directed staff to evaluate the environment for possible contributing factors and address them and directed the IDT to review the falls and the care plan changes and if needed implement additional interventions.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 12, 2024

Administrator
Villa St. Vincent
516 Walsh Street
Crookston, MN 56716

Re: State Nursing Home Licensing Orders
Event ID: BKRW11

Dear Administrator:

The above facility was surveyed on March 28, 2024 through April 2, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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:

Susie Haben, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
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
	00815	A. BUILDING: _____ B. WING _____	C 04/02/2024

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/28/24 thorough 3/29/24 and 4/2/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have	2 000		

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2 000	Continued From page 1 reviewed these orders and identify the date when they will be completed. The following complaints were reviewed with no deficiency issued. H54842357C (MN101850) H54842572C (MN101479) H54842571C (MN101758) H54842711C (MN102018) The following complaints were reviewed. H54842573C (MN101708) with a licensing order issued at 0830. 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 electronic State licensure process, under the	2 000		

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2 000	Continued From page 2 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 develop and implement interventions to ensure adequate supervision for 1 of 1 residents (R5) reviewed who had multiple incidents of unsafe behavior related to marijuana use.	2 830	Corrected	5/1/24

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2 830	Continued From page 3 Findings include: R5's face sheet identified diagnosis that included Schizo-affective disorder, dementia without behaviors, mood disturbance and anxiety. R5's quarterly Minimum Data Set (MDS) dated 3/15/24, identified moderate cognitive impairment. The MDS indicated R5 had hallucinations and did not display any behaviors. The MDS indicated R5 was independent with mobility, transfers and ambulation and had sustained two or more falls since the previous assessment. R5's Fall Risk and Functional Limitation Observation dated 3/15/24, identified intermittent confusion and use of assistive devices. The observation identified the use of marijuana. The observation indicated both physical and cognitive limitations increased R5's risk for falls and indicated she had three falls since the previous observation period. The observation identified the use of recreational marijuana but lacked assessment related to how the marijuana use affected R5's physical functioning and falls. R5's care plan dated 3/18/24, indicated she smoked recreational marijuana. The care plan indicated R5 had a smoking contract in place and would practice safe smoking habits. The care plan directed staff to remind R5 she was not to be unaccompanied when ambulating outside the facility due to her choice of marijuana use but indicated R5 was not always compliant. The care plan further identified a risk for falls. R5's Marijuana Use Contract updated 3/20/24, indicated nursing staff was able to restrict access	2 830		

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2 830	Continued From page 4 to the smoking area outside if R5 appeared medically unstable or too intoxicated to safely perform activities of daily living including but not limited to steady walking, keeping eyes open, dressing appropriately, able to communicate and able to pass a safe smoking evaluation. The contract indicated R5 would limit her marijuana use to three times per day, two one-hitters (used to smoke marijuana) between the hours of 6:00 a.m. and 2:00 a.m. R5's facility Progress Notes identified the following: 3/6/24, R5 attempted to go out to the smoke shack and writer denied her due to R5's eyes being barely open. Later, around midnight, NA spotted her on the camera in the smoke shack. 3/9/24, at approximately 1:00 a.m. R5 wanted to go out to the smoke shack. Writer told her no as her eyes were barely open and she was wearing only her bra with a winter coat unzipped. R5 went back to her room and returned about 30 minutes later with a shirt on but no coat and went out to smoke. 3/13/24, R5 was awake all night going to the smoke shack, eyes barely open and sometimes going when staff were with other residents. 3/15/24, R5 went to nurses station, gait somewhat unsteady and eyes closed. When R5 opened her eyes they were red and R5 had slurred speech. Writer asked R5 not to go to the smoke shack and R5 stated she had just woken up. R5 had been to the smoke shack at least 4-5 times. 3/17/24, At approximately 12:15 a.m. R5 was	2 830		

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2 830	Continued From page 5 found on the floor by staff. R5 had just gone out to smoke and smelled like marijuana. 3/18/24, R5 was observed on the floor watching a movie and asked for assistance back to bed. Writer asked her how she got on the floor and R5 stated, "I was waiting for the floor to come to me and it took so long so I came to the floor" and said "I had important things to do with the floor." It was noted 20 minutes before, R5 had been in the smoke shack smoking her marijuana. When asked if she was okay R5 stated, "yes, I'm just high." 3/18/24, IDT discussed falls. R5 had fallen twice and had been smoking marijuana prior to each fall. Interventions to revisit contract and provide education. 3/18/24, Another resident reported that R5 was "sleepwalking" and went into another residents room around 4:00 a.m. 3/29/24, R5 was noted to come back inside facility with no jacket and her walker in the smoking area. 3/29/24, R5 was noted to be in another residents room attempting to remove the toilet seat riser. Staff assisted R5 back to her room. R5 stated she was going out to smoke and was not able to be redirected. During observation on 3/28/24 at 2:53 a.m., R5 ambulated independently from her room to the smoke shack outside wearing a long shirt, jacket and shoes. R5 was not wearing any pants and her shirt only reached to just below her buttocks. No staff were observed in the vicinity. R5 could be seen on the camera at the nurses station in the smoking shack. R5 left the smoking area and returned to the building at 3:02 p.m. At 4:03 p.m.	2 830		

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2 830	Continued From page 6 R5 again ambulated out to the smoking area. R5 was wearing pants at this time. R5 was seen on the camera smoking a cigarette and returned to the building at 4:07 p.m. Again no staff was in the area. At 4:32 p.m. R5 was again observed on camera in the smoke shack. R5 had a locked box she placed under the seat of her walker. At 4:36 p.m. R5 entered the building and returned to her room. At 5:04 p.m. R5 left her room and ambulated out to the smoking area. R5 was seen on the camera as she entered to smoking area. R5 removed a locked metal box from under the seat of her walker and lit and smoked a "one hitter." At 5:09 p.m. R5 returned the box under the seat of her walker, exited the shack and returned to her room. During the observations, no staff were in the vicinity of the nurses station. During interview on 3/29/24 at 9:36 a.m., NA-A stated she did not usually work on the unit but said she was aware R5 had falls. NA-A said fall interventions were listed on the care sheets. NA-A said she was aware R5 smoked marijuana and said she was allotted a certain amount each day but was not sure how much or how often. NA-A said she was not in charge of monitoring when R5 went outside. During interview on 3/29/24 at 9:45 a.m., NA-B stated she was a little bit familiar with R5. NA-B said she was aware R5 was allowed to smoke marijuana and thought R5 had to sign out. NA-B said she did not know about any of R5's falls. During interview on 3/29/24 at 9:55 a.m., NA-C stated he was aware R5 was a fall risk and said fall interventions were on the care sheet. NA-C said R5 had a plan for her marijuana use and said one time he saw the paper (contract). NA-C said if R5 wanted to smoke she had to ask	2 830		

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2 830	Continued From page 7 whoever was at the desk and had to sign out on a sign out sheet. During interview on 3/29/24 at 10:06 a.m., registered nurse (RN)-B stated R5 had not fallen on the day shift but had a recent fall on the p.m. to overnight shift. RN-B said fall interventions included proper footwear and said that was the only intervention she was aware of. RN-B stated R5 smoked marijuana and said she did that on her own. RN-B said R5 had her own stuff, managed it on her own and did not tell staff when she was using it. RN-B said if she saw R5 going outside she would assess if she saw signs of her being high, like if she was able to talk to her, still standing and dressed appropriately. RN-B said there were times when she had to remind R5 to dress appropriately. RN-B further stated she had not received any direction to monitor when or what R5 was smoking. During interview on 3/29/24 at 10:15 a.m., trained medication aide (TMA)-A stated she was not sure what R5's fall interventions were but said she was aware R5 had fallen. TMA-A stated she was aware R5 smoked marijuana and said she believed there was a contract in place that placed restrictions on the times R5 could smoke. TMA-A stated R5 started using marijuana at the facility when it became legal and said she was not aware of any falls when R5 was outside or when she was "high." During interview on 3/29/24 at 10:21 a.m., R5 stated she had been trying to do what the facility asked, staying away from other people while smoking marijuana. R5 said they check to make sure she was not stoned enough that she fell and said "I've done that before." R5 said she doesn't have to check out. R5 said they told her she	2 830		

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2 830	Continued From page 8 could smoke marijuana three times per day but said nobody monitors it. R5 said she had been smoking marijuana at the facility for a little over a year but had told the facility when it became legal. When asked how many of her falls occurred when she was under the influence of marijuana, R5 stated 50%. During interview on 3/29/24 at 10:27 a.m., NA-D stated she only worked on the unit about once a month but was familiar with R5. In regard to R5's marijuana use, NA-D said "I feel like she is kind of overdoing it a little bit." NA-D said R5 couldn't keep her eyes open and said she acts kind of "zombie-ish." NA-D said she was not aware of any restrictions on R5's marijuana use. On 3/29/24 at 10:56 a.m., registered nurse (RN)-A and licensed social worker (LSW)-A were interviewed. RN-A stated a lot of R5's falls were due to non-compliance with footwear. RN-A said maintenance had replaced the wheels on R5's walker because they were not locking and said a lot of education was given to R5. RN-A reviewed R5's medical record and said she had not fallen since January of 2024. When questioned about the most recent falls RN-A confirmed R5 had fallen in March 2024, and said following that fall she and LSW-A had talked to her about her marijuana use safety contract. RN-A stated R5 had denied the marijuana was causing her falls. In regard to the smoking assessment that was completed due to R5's increase in falls, RN-A stated it was completed to determine if R5 was still safe to smoke. RN-A acknowledged the assessment did not address R5's ability to safely get to the smoking area. RN-A stated if a resident who smoked cigarettes was falling they would assess if they were safe to get to the smoking area and return. LSW-A stated usually at night	2 830		

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2 830	Continued From page 9 staff would tell R5 she was not safe to go outside. LSW-A said from what she had read, R5 was able to sign herself out even if she was impaired. LSW-A said the charge nurse would advise R5 not to go outside if staff felt like she was not safe. LSW-A stated the charge nurses knew they were responsible to monitor R5. When asked how it was communicated to the charge nurses, RN-A stated "they know." LSW-A said R5 agreed as part of her marijuana use contract to only smoke it 2-3 times per day but said all staff could do was kind of watch to see how many times R5 was going outside. LSW-A said the facility has been aware of R5's marijuana use since August of 2024. During interview on 4/2/24 at 11:58 a.m., the director of nursing (DON) stated when R5 began smoking marijuana at the facility she would go outside and sit in an area that was not the designated smoking area. The DON stated the facility did not have a marijuana use policy and said LSW-A and RN-A had many conversations with R5 to come up with a compromise. The DON said R5 had proposed the idea about using the one hitter three times a day but after she agreed she decided it wasn't enough. The DON stated due to the falls, the facility encouraged her to alert staff or to sign out so someone could monitor the amount of time she was out. The DON said if staff were aware and R5 appeared to be under the influence they tried to watch the cameras but said they did not have anyone designated to supervise R5. Facility Integrated Fall Management policy dated 8/24/17, indicated fall risk assessment, identification and implementation of appropriate interventions were necessary to maintain resident safety. The policy indicated care planned	2 830		

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2 830	Continued From page 10 interventions were based on the finding of the fall risk assessment. The policy directed staff to evaluate the environment for possible contributing factors and address them and directed the IDT to review the falls and the care plan changes and if needed implement additional interventions. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions 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		