Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 10, 2025

Administrator
Villa St Vincent
516 Walsh Street
Crookston, MN 56716

RE: CCN: 245484
Cycle Start Date: June 5, 2025

Dear Administrator:

On June 24, 2025, we notified you a remedy was imposed. On July 2, 2025 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 2, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 9, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 24, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 9, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 2, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 10, 2025

Administrator
Villa St Vincent
516 Walsh Street
Crookston, MN 56716

Re: Reinspection Results
Event ID: 419112

Dear Administrator:

On July 2, 2025 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 June 5, 2025. 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 24, 2025

Administrator
Villa St Vincent
516 Walsh Street
Crookston, MN 56716

RE: CCN: 245484
Cycle Start Date: June 5, 2025

Dear Administrator:

On June 5, 2025, 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 actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective July 9, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 9, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 9, 2025.

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

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 9, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Villa St Vincent will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 9, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

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.

DEPARTMENT CONTACT

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

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 5, 2025 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 24, 2025

Administrator
Villa St Vincent
516 Walsh Street
Crookston, MN 56716

Re: State Nursing Home Licensing Orders
Event ID: 419111

Dear Administrator:

The above facility was surveyed on June 4, 2025 through June 5, 2025 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
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
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
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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 06/05/2025

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 6/4/25 through 6/5/25, 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 complaint was reviewed H54846327C (MN00113546), 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=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 accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure care planned	F 689	During the survey process it was noted that the facility failed to ensure the care	7/2/25

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

Electronically Signed | 06/26/2025

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
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F 689	Continued From page 1 interventions to reduce the risk for falls were followed for 2 of 4 residents (R1, R3). This resulted in actual harm for R1 who fell and sustained a vertebral fracture. Findings include: R1's Resident Face Sheet indicated she admitted to the facility 1/30/24. Diagnosis included dementia, fracture of T (thoracic) 11- T12 vertebrae, difficulty walking, muscle weakness and age related osteoporosis. R1's quarterly Minimum Data Set (MDS) dated 4/21/25, identified moderate cognitive impairment. The MDS indicated R1 required partial to moderate assistance and did not ambulate due to medical condition or safety concerns and had no falls since the prior assessment. R1's assessment for Fall Risk and Functional Limitation dated 4/22/25, identified intermittent confusion, balance problem while standing, impaired mobility and indicated R1 utilized a wheelchair. The assessment score of 16 indicated a high risk for falls. R1's care plan dated 5/16/25, identified a self-care deficit and indicated she needed assistance with bed mobility, transfers, ambulation and locomotion due to a history of a fall with hip fracture. The care plan identified a high risk for falls and indicated all standard fall interventions were in place. An undated, untitled nursing assistant (NA) care guide directed staff to provide extensive assistance of one to two staff with transfer and	F 689	planned fall interventions were followed for 2 residents of 4 residents reviewed. The facility failed to develop a process to guide nursing staff of the facilities expectation for following the care plan and utilizing the CNA group sheets to ensure residents receive required level of assistance and appropriate assistive devises. R1- staff education was provided to the staff involved on 6/3/25. R3- staff education on the fall intervention care planned for the resident involved as the documented intervention was to place slip grip to the resident recliner (located in his room) and his w/c. R3s care plan has been updated to reflect slip grip applied residents recliner located in his room. We have devised and initiated a plan to educate and monitor nursing personnel on the use and flow of care plans and CNA group sheets to guide them through out each and every shift. All residents have the ability to be affected by this deficient practice. We are in the process of completing a full house audit to ensure care plans & group sheets are accurate this will be completed by 6/27/25. Surveillance audits of cares are being conducted to ensure that no other resident have been affected by the deficient practice this was initiated will be completed by 7/2/25. Education is being provided to all nursing personnel on the facilities expectation regarding the use, function and flow of the care plan & CNA group sheets this will be completed by 6/30/25. The facilitys policy/	

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F 689	Continued From page 2 directed staff to utilize a wheelchair for transport. R1's Resident Progress Notes indicated the following: -5/30/25, Nurse was called to the hallway outside of R1's room where she was on the floor sitting with NA-A behind her, and both legs in front of her. Per NA-A, R1 fell around the corner. R1 complained of pain to her buttocks. -5/31/25, R1 was experiencing severe back pain rated 9/10 on pain scale. R1 was clenching her fists and grimacing and refused to roll over due to pain. New order received to increase Tramadol (used for the management of moderate to moderately severe pain) to 50 milligrams (mg) every four hours as needed. -6/1/25 at 10:58 a.m., R1 continued to complain of pain in her back. Family member requested R1 be sent to the emergency department (ED) for further evaluation. 6/1/25 at 1:45 p.m., received call from ED staff who reported R1 sustained a T12 compression fracture (a type of fracture where a vertebra in the spine is compressed or collapses). 3:05 p.m., R1 returned from ED with the following orders: Start taking Hydrocodone-acetaminophen (combination prescription medication used to treat moderate to severe pain) 5 mg-325 mg, 1 tablet every six hours as needed for moderate or severe pain if not controlled by Tramadol. R1's ED Provider Note dated 6/1/25, indicated she presented to the ED for pain. The note indicated R1 experienced constant pain that started two days prior as a result of a fall. Pain was present in the lumbar spine and symptoms	F 689	process has been reviewed and revised on 6/25/25. To ensure compliance; a minimum of 5 resident audits will be conducted by the DON or their designee each week, of care provided to ensure residents plan of care in relation to their care planned interventions are followed. Audits will be ongoing for 4 months and/or as determined by quality council based on continued compliance. Audit results will be reviewed by quality council for monitoring and assured compliance. Facility will achieve substantial compliance by 7/2/25.	

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F 689	Continued From page 3	F 689		

were aggravated by bending, twisting and certain positions. Tramadol provided no relief. Lumbar computed tomography scan (a medical imaging test that uses X-rays and computers to create detailed images of the lower spine) showed a T12 compression fracture.

During interview on 6/4/25 at 6:33 p.m., registered nurse (RN)-A stated staff had reported R1 was in the hallway and started to slowly fall so NA-A lowered R1 to the ground. RN-A stated R1 did not typically ambulate, but NA-A had been walking with her at the time of the fall. RN-A stated NA-A had not used a transfer belt when walking with R1. RN-A said R1's family did not want her walking after she sustained a hip fracture the previous year and said the NA care sheet directed staff to utilize a wheelchair.

During interview on 6/4/25 at 6:50 p.m., the assistant director of nursing (ADON) stated NA-A should have known not to ambulate with R1 and should have utilized a transfer belt. The ADON said NA-A received education following the incident and all staff received training on following resident fall interventions.

During interview on 6/5/25 at 8:18 a.m., NA-A stated on 5/30/25, at approximately 5:00 p.m., she had been doing rounds on the unit. NA-A said she went to R1's room to bring her to the dining room and said she had been distracted and forgot about the transfer belt. NA-A said she got R1 up and out to the hallway and said R1 was holding on to the walker with one hand and the hand rail with the other hand. NA-A said after they got about four feet from R1's room, R1 stopped and said it was too far, then let go of the railing. NA-A said that was when she realized she had

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F 689	Continued From page 4 forgotten the gait belt so she "somewhat" grabbed R1 and went to the floor with her. NA-A stated she had been working at the facility for almost four months and said she had not been trained on the care plan when she started but was trained following the fall incident. During interview on 6/5/25 at 9:05 a.m., NA-B stated she had been working the night of R1's fall. NA-B said NA-A went to get R1 up for dinner and said NA-A did not look at the care guide and thought R1 could walk. NA-B said R1 had not walked with staff since she had broken a bone in the past. NA-B said NA-A also had not used a transfer belt when walking with R1. During interview on 6/5/25 at 12:07 p.m., NA-E stated R1 participated in a range of motion program but said she did not ambulate with staff. NA-E said the last time he had seen R1 walk with staff was the previous year. During interview on 6/5/25 at 12:13 p.m., NA-F said R1 fell because the staff person walking with her did not use a transfer belt. NA-F said he had never seen staff walk with R1 and said the care guide said to use the wheelchair for long distances. R3's Resident Face Sheet indicated he admitted to the facility 4/17/25. Diagnosis included traumatic subdural hemorrhage with loss of consciousness, Alzheimer's disease, maxillary fracture (a break in the bones surrounding the maxillary sinus, which are air-filled spaces in the cheekbones), fracture of lateral orbital wall (break in the outer wall of the eye socket) of right eye, muscle weakness and repeated falls.	F 689		

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F 689	Continued From page 5 R3's assessment for Fall Risk and Functional Limitation dated 5/5/25, indicated he was disoriented, required the use of assistive devices and had impaired mobility. The assessment identified a fall score of 20 which indicated high risk. R3's 5-day MDS dated 5/11/25, identified severe cognitive impairment and indicated he required supervision for transfers and partial to moderate assistance for toileting. The MDS indicated ambulation was not attempted due to medical condition or safety concerns and indicated he had one fall since the prior assessment. R3's care plan dated 5/20/25, identified impaired physical mobility related to cognitive decline secondary to dementia. The care plan directed staff to provide assistance from two caregivers during all transfers and ambulation. The care plan further identified a high risk for falls due to a history of falls. Fall interventions included; remove leg rests when not pushing R3 in the wheelchair, auto lock brakes on wheelchair, and transfer belt at all times. R3's NA care guide, undated identified fall interventions that included slip grip to wheelchair and recliner chair. R3's Resident Progress Notes indicated the following: -5/1/25, progress note indicated, R1 had been leaning to his right side in the wheelchair and slid out of the chair. (no time indicated) -5/1/25, R3 had a second fall, progress note	F 689		

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	245484	A. BUILDING _____ B. WING _____	C 06/05/2025

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F 689	Continued From page 6 indicated at approximately 2:40 p.m., R1 had an unwitnessed fall from his wheelchair, landing on the floor and striking his head. R3 was found lying on his left side the hallway. R3 verbalized pain to his forehead. Staff noted a raised area on R3's forehead. 5/1/25, Interdisciplinary team (IDT) reviewed the falls. Intervention to ensure slip grip was applied when in wheelchair. -5/5/25, progress note indicated R3 returned from the hospital where he had been admitted on 5/1/25. Hospital diagnosis included acute subdural hematoma (a life-threatening condition where blood collects between the brain and its outer lining, the dura mater, following a head injury), acute non-displaced fractures of right maxillary sinus and right lateral orbit, and metabolic encephalopathy (a change in how your brain works due to an underlying condition), likely due to urinary tract infection. -5/6/25, progress note indicated IDT reviewed fall and implemented Slip Grip to recliner chair. -5/16/25, progress note indicated R3 experienced a fall from a wheelchair. Staff determined the wheelchair utilized at the time of the fall did not belong to R3. -5/18/25, R3 had an unwitnessed fall in his room. -5/25/25, R3 had a fall in the dining room. -5/27/25, R3 had two falls, the first fall, R3 was found on the floor in his room. The second fall R3 fell attempting to ambulate in the television room. -6/1/25, R3 fell after attempting to stand up from his wheelchair and sustained a laceration above	F 689		

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F 689	Continued From page 7 his right eye. -6/2/25, R3 had an unwitnessed fall and was found on his back with his leg tangled in the footrest of his wheelchair. During interview on 6/5/25 at 11:47 a.m., NA-C stated R3 required one person to transfer and could walk using a gait belt. When asked about fall interventions, NA-C was not sure where to look. NA-C pulled the resident care guide out of her pocket, looked at it and said, "I'm not really seeing a lot," then said no interventions were listed on the care guide. (interventions were listed on the back of care guide) During interview on 6/5/25 at 11:51 a.m., NA-D said they used two staff to assist R3 due to behaviors. Regarding fall interventions, NA-D said staff just monitored him closely and said he had a motion detection device in his room. During observation and interview on 6/5/25 at 11:59 a.m., R3 was seated in a chair in the television area of the unit with his legs crossed and his eyes closed. R3 was seated on a soaker pad and did not appear to have slip grip underneath him. RN-B was interviewed and acknowledged no slip grip had been placed under R3 in the chair. RN-B stated R3 was care planned to have slip grip in his wheelchair and his recliner chair. RN-B said he should have it in any chair he was sitting in. RN-B stated fall interventions were on the NA care guides. The care guide was reviewed with RN-B and fall interventions, including the slip grip were listed on the backside of the paper. Facility policy Comprehensive Assessment and	F 689		

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F 689	Continued From page 8 Care Planning dated 9/27/23, indicated the facility should use the results of the assessment to develop, review and revise the residents person-centered comprehensive care plan. All person-centered care plan interventions will be implemented by qualified personnel. Interventions may be communicated through the electronic health record, resident profile, assignment sheets, and/or verbal communication.	F 689		

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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 6/4/25 through 6/5/25, 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 orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H54846327C (MN00113546), 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 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	2 000		

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2 000	Continued From page 2 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 ensure care planned interventions to reduce the risk for falls were followed for 2 of 4 residents (R1, R3). This resulted in actual harm for R1 who fell and sustained a vertebral fracture. Findings include: R1's Resident Face Sheet indicated she admitted to the facility 1/30/24. Diagnosis included	2 830	Corrected	7/2/25

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2 830	Continued From page 3 dementia, fracture of T (thoracic) 11- T12 vertebrae, difficulty walking, muscle weakness and age related osteoporosis. R1's quarterly Minimum Data Set (MDS) dated 4/21/25, identified moderate cognitive impairment. The MDS indicated R1 required partial to moderate assistance and did not ambulate due to medical condition or safety concerns and had no falls since the prior assessment. R1's assessment for Fall Risk and Functional Limitation dated 4/22/25, identified intermittent confusion, balance problem while standing, impaired mobility and indicated R1 utilized a wheelchair. The assessment score of 16 indicated a high risk for falls. R1's care plan dated 5/16/25, identified a self-care deficit and indicated she needed assistance with bed mobility, transfers, ambulation and locomotion due to a history of a fall with hip fracture. The care plan identified a high risk for falls and indicated all standard fall interventions were in place. An undated, untitled nursing assistant (NA) care guide directed staff to provide extensive assistance of one to two staff with transfer and directed staff to utilize a wheelchair for transport. R1's Resident Progress Notes indicated the following: -5/30/25, Nurse was called to the hallway outside of R1's room where she was on the floor sitting with NA-A behind her, and both legs in front of her. Per NA-A, R1 fell around the corner. R1 complained of pain to her buttocks.	2 830		

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2 830	Continued From page 4 -5/31/25, R1 was experiencing severe back pain rated 9/10 on pain scale. R1 was clenching her fists and grimacing and refused to roll over due to pain. New order received to increase Tramadol (used for the management of moderate to moderately severe pain) to 50 milligrams (mg) every four hours as needed. -6/1/25 at 10:58 a.m., R1 continued to complain of pain in her back. Family member requested R1 be sent to the emergency department (ED) for further evaluation. 6/1/25 at 1:45 p.m., received call from ED staff who reported R1 sustained a T12 compression fracture (a type of fracture where a vertebra in the spine is compressed or collapses). 3:05 p.m., R1 returned from ED with the following orders: Start taking Hydrocodone-acetaminophen (combination prescription medication used to treat moderate to severe pain) 5 mg-325 mg, 1 tablet every six hours as needed for moderate or severe pain if not controlled by Tramadol. R1's ED Provider Note dated 6/1/25, indicated she presented to the ED for pain. The note indicated R1 experienced constant pain that started two days prior as a result of a fall. Pain was present in the lumbar spine and symptoms were aggravated by bending, twisting and certain positions. Tramadol provided no relief. Lumbar computed tomography scan (a medical imaging test that uses X-rays and computers to create detailed images of the lower spine) showed a T12 compression fracture. During interview on 6/4/25 at 6:33 p.m., registered nurse (RN)-A stated staff had reported R1 was in the hallway and started to slowly fall so NA-A lowered R1 to the ground. RN-A stated R1	2 830		

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2 830	Continued From page 5 did not typically ambulate, but NA-A had been walking with her at the time of the fall. RN-A stated NA-A had not used a transfer belt when walking with R1. RN-A said R1's family did not want her walking after she sustained a hip fracture the previous year and said the NA care sheet directed staff to utilize a wheelchair. During interview on 6/4/25 at 6:50 p.m., the assistant director of nursing (ADON) stated NA-A should have known not to ambulate with R1 and should have utilized a transfer belt. The ADON said NA-A received education following the incident and all staff received training on following resident fall interventions. During interview on 6/5/25 at 8:18 a.m., NA-A stated on 5/30/25, at approximately 5:00 p.m., she had been doing rounds on the unit. NA-A said she went to R1's room to bring her to the dining room and said she had been distracted and forgot about the transfer belt. NA-A said she got R1 up and out to the hallway and said R1 was holding on to the walker with one hand and the hand rail with the other hand. NA-A said after they got about four feet from R1's room, R1 stopped and said it was too far, then let go of the railing. NA-A said that was when she realized she had forgotten the gait belt so she "somewhat" grabbed R1 and went to the floor with her. NA-A stated she had been working at the facility for almost four months and said she had not been trained on the care plan when she started but was trained following the fall incident. During interview on 6/5/25 at 9:05 a.m., NA-B stated she had been working the night of R1's fall. NA-B said NA-A went to get R1 up for dinner and said NA-A did not look at the care guide and thought R1 could walk. NA-B said R1 had not	2 830		

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2 830	Continued From page 6 walked with staff since she had broken a bone in the past. NA-B said NA-A also had not used a transfer belt when walking with R1. During interview on 6/5/25 at 12:07 p.m., NA-E stated R1 participated in a range of motion program but said she did not ambulate with staff. NA-E said the last time he had seen R1 walk with staff was the previous year. During interview on 6/5/25 at 12:13 p.m., NA-F said R1 fell because the staff person walking with her did not use a transfer belt. NA-F said he had never seen staff walk with R1 and said the care guide said to use the wheelchair for long distances. R3's Resident Face Sheet indicated he admitted to the facility 4/17/25. Diagnosis included traumatic subdural hemorrhage with loss of consciousness, Alzheimer's disease, maxillary fracture (a break in the bones surrounding the maxillary sinus, which are air-filled spaces in the cheekbones), fracture of lateral orbital wall (break in the outer wall of the eye socket) of right eye, muscle weakness and repeated falls. R3's assessment for Fall Risk and Functional Limitation dated 5/5/25, indicated he was disoriented, required the use of assistive devices and had impaired mobility. The assessment identified a fall score of 20 which indicated high risk. R3's 5-day MDS dated 5/11/25, identified severe cognitive impairment and indicated he required supervision for transfers and partial to moderate assistance for toileting. The MDS indicated ambulation was not attempted due to medical	2 830		

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2 830	Continued From page 7 condition or safety concerns and indicated he had one fall since the prior assessment. R3's care plan dated 5/20/25, identified impaired physical mobility related to cognitive decline secondary to dementia. The care plan directed staff to provide assistance from two caregivers during all transfers and ambulation. The care plan further identified a high risk for falls due to a history of falls. Fall interventions included; remove leg rests when not pushing R3 in the wheelchair, auto lock brakes on wheelchair, and transfer belt at all times. R3's NA care guide, undated identified fall interventions that included slip grip to wheelchair and recliner chair. R3's Resident Progress Notes indicated the following: -5/1/25, progress note indicated, R1 had been leaning to his right side in the wheelchair and slid out of the chair. (no time indicated) -5/1/25, R3 had a second fall, progress note indicated at approximately 2:40 p.m., R1 had an unwitnessed fall from his wheelchair, landing on the floor and striking his head. R3 was found lying on his left side the hallway. R3 verbalized pain to his forehead. Staff noted a raised area on R3's forehead. 5/1/25, Interdisciplinary team (IDT) reviewed the falls. Intervention to ensure slip grip was applied when in wheelchair. -5/5/25, progress note indicated R3 returned from the hospital where he had been admitted on 5/1/25. Hospital diagnosis included acute subdural hematoma (a life-threatening condition where blood collects between the brain and its	2 830		

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2 830	Continued From page 8 outer lining, the dura mater, following a head injury), acute non-displaced fractures of right maxillary sinus and right lateral orbit, and metabolic encephalopathy (a change in how your brain works due to an underlying condition), likely due to urinary tract infection. -5/6/25, progress note indicated IDT reviewed fall and implemented Slip Grip to recliner chair. -5/16/25, progress note indicated R3 experienced a fall from a wheelchair. Staff determined the wheelchair utilized at the time of the fall did not belong to R3. -5/18/25, R3 had an unwitnessed fall in his room. -5/25/25, R3 had a fall in the dining room. -5/27/25, R3 had two falls, the first fall, R3 was found on the floor in his room. The second fall R3 fell attempting to ambulate in the television room. -6/1/25, R3 fell after attempting to stand up from his wheelchair and sustained a laceration above his right eye. -6/2/25, R3 had an unwitnessed fall and was found on his back with his leg tangled in the footrest of his wheelchair. During interview on 6/5/25 at 11:47 a.m., NA-C stated R3 required one person to transfer and could walk using a gait belt. When asked about fall interventions, NA-C was not sure where to look. NA-C pulled the resident care guide out of her pocket, looked at it and said, "I'm not really seeing a lot," then said no interventions were listed on the care guide. (interventions were listed on the back of care guide)	2 830		

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2 830	Continued From page 9 During interview on 6/5/25 at 11:51 a.m., NA-D said they used two staff to assist R3 due to behaviors. Regarding fall interventions, NA-D said staff just monitored him closely and said he had a motion detection device in his room. During observation and interview on 6/5/25 at 11:59 a.m., R3 was seated in a chair in the television area of the unit with his legs crossed and his eyes closed. R3 was seated on a soaker pad and did not appear to have slip grip underneath him. RN-B was interviewed and acknowledged no slip grip had been placed under R3 in the chair. RN-B stated R3 was care planned to have slip grip in his wheelchair and his recliner chair. RN-B said he should have it in any chair he was sitting in. RN-B stated fall interventions were on the NA care guides. The care guide was reviewed with RN-B and fall interventions, including the slip grip were listed on the backside of the paper. Facility policy Comprehensive Assessment and Care Planning dated 9/27/23, indicated the facility should use the results of the assessment to develop, review and revise the residents person-centered comprehensive care plan. All person-centered care plan interventions will be implemented by qualified personnel. Interventions may be communicated through the electronic health record, resident profile, assignment sheets, and/or verbal communication. 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	2 830		

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 06/05/2025

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) COMPLETE DATE
2 830	Continued From page 10 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		