Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 11, 2024

Administrator
Villa St Vincent
516 Walsh Street
Crookston, MN 56716

Re: Reinspection Results
Event ID: ECG412

Dear Administrator:

On September 5, 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 August 9, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
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
September 11, 2024

Administrator
Villa St Vincent
516 Walsh Street
Crookston, MN 56716

RE: CCN: 245484
Cycle Start Date: July 31, 2024

Dear Administrator:

On August 20, 2024, we notified you a remedy was imposed. On September 9, 2024 the Minnesota Departments of Health and Public Safety 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 September 2, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 4, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 20, 2024, 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 September 4, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 2, 2024, 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 Therefore, the NATCEP prohibition is rescinded.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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Email: Kamala.Fiske-Downing@state.mn.us

An equal opportunity employer.

Electronically delivered
August 20, 2024

Administrator
Villa St Vincent
516 Walsh Street
Crookston, MN 56716

RE: CCN: 245484
Cycle Start Date: July 31, 2024

Dear Administrator:

On August 9, 2024, we informed you of imposed enforcement remedies.

On August 9, 2024, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 4, 2024.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 4, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 4, 2024.

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.

As we notified you in our letter of August 9, 2024, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from

conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 31, 2024. However, due to the extended survey the new NATCEP loss date is September 4, 2024.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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

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

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

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, Rapid Response
Licensing and Certification Program
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

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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 31, 2025 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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:

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ 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

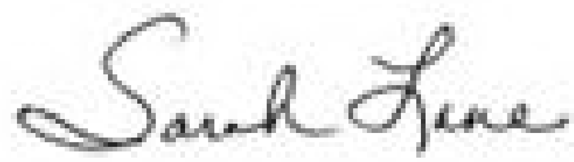
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@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 08/09/2024

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 8/8/24 through 8/9/24, 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 complaint was reviewed: H54846644C (MN105462) with a deficiency cited at F600 at Harm. 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 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		8/30/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 08/23/2024

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 600	Continued From page 1 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement interventions to protect 2 of 2 residents (R1, R2) from resident to resident abuse when R2, who had a history of pushing other residents, initiated an altercation with R1 which resulted in R1's transport to the Emergency Department (ED) for a scalp laceration repaired with sutures. This resulted in harm for R1. Findings include: R2's Resident Face Sheet indicated he admitted to the facility 11/3/22. R2's diagnosis included Alzheimer's disease, depression, dementia, obsessive compulsive disorder (OCD), unspecified head injury and disorientation. R2's care plan dated 8/2/24, identified a risk for impaired psychosocial well-being due to cognitive impairment and indicated he could become aggressive toward others. The care plan further identified a risk for harming others and indicated he had been aggressive (pushed) another resident. The care plan identified the use of a stop sign on R2's door to deter others from entering and directed staff to close door when appropriate and re-direct R2 or others away if showing agitation. R2's Observation Detail List, Behavior Conditions dated 8/2/24, identified Alzheimer's Disease,	F 600	During the survey process it was noted that the facility failed to implement interventions to protect 2 of 2 residents. The facility failed to have a clear process in place to initiate direct supervision at the time of the incident. On 8/9/2024 the facility designated an individual staff to provide direct supervision of R2 24 hours a day 7 days a week. A behavior log and staff interviews were initiated on 8/8/2024 to identify R2's activities and identify triggers to devise a long-term plan of care. All information obtained was reviewed by the leadership team. A list of triggers have been identified through staff interview and resident observation. An additional staff will be assigned to the MCU to cover the identified trigger time frames. A review was completed of R1's record and plan of care were competed on 8/12/24, no revisions warranted at this time. All MCU resident have the ability to be affected by this deficient practice. All residents in MCU have been audited to ensure proper interventions have been provided. R1 is the only resident affected by the practice. On a case by case basis, the Executive Director and/or DON may initiate direct supervision for resident to resident altercations until the full investigation has been completed and	

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F 600 Continued From page 2

subarachnoid hemorrhage, OCD and depression. The observation indicated physical behaviors toward others occurred 1-3 of the past seven days and indicated the behaviors put others at significant risk for injury.

R2's Resident Progress Notes identified the following:
-7/25/24, R2 stated to nursing assistant (NA) he had had pushed another resident who had come into his room.
-8/1/24, R2 was seen pushing another resident that morning. When approached R2 stated, "she was taking his walker." Resident informed it was not appropriate to push residents.
-8/4/24, 1:09 p.m. R2 noted to be entering other residents rooms. Denied when approached until staff mentioned he had been seen entering or leaving another's room.

During observation on 8/8/24 at 12:22 p.m., R2 was observed leaving the dining room. He entered his room, re-applied a Velcro stop sign to his door, and shut the door.

R1's Resident Face Sheet indicated she admitted to the facility 10/19/23. R1's diagnosis included Alzheimer's Disease, head laceration, dementia, anxiety and depression.

R1's care plan dated 7/29/24, identified inappropriate behaviors exhibited by wandering into other residents rooms, taking things and becoming defensive/combative with directions. The care plan indicated R1 was unaware of personal boundaries and property and did not appear to comprehend direction. The care plan directed if R1 was wandering in potentially dangerous area or near residents known for

F 600

reviewed by the Interdisciplinary Team.

Facility policy on abuse prevention was reviewed and no revisions made. A process has been added for the facility Executive Director and / or DON. An audit was completed to ensure proper interventions have been provided. R1 is the only resident affected by the practice. The Executive Director and/or DON will initiate direct supervision as warranted resident to resident altercations with suspected injury or a pattern has emerged until the full investigation has been completed and reviewed by the Interdisciplinary Team.

Education will be provided to all licensed nurses on the importance of timely notification of administration/DON regarding resident to resident incidents. The expectation of an event being initiated in Matrix for tracking purposes. Each event will be reviewed by IDT the first week day following the event. All staff will be educated on the importance of observing the environment and utilizing additional team members to ensure there is direct supervision during identified triggers. The facility Executive Director, DON and their designee have been educated on the process of initiating direct supervision for resident to resident altercations when an injury is suspected or a pattern has emerged until the investigation has been completed and the resident specific plan of care has been developed. Education for all licensed staff, DON and Executive Director by August

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F 600	Continued From page 3 agitation/aggression to escort away and provide diversional activity. The care plan further indicated she had been a victim of another resident's physical aggression. R1's Resident Progress Notes indicated the following: -8/4/24, 1:30 p.m. R1 was attempting to push residents around in their wheelchairs multiple times. Redirection attempted without success. -8/4/24, 4:37 p.m. R1 was found lying on her back on the floor in the common area with a pool of blood under her head. R1 complained of pain to her coccyx. Sent to ED. R1's ED visit note dated 8/4/24, indicated she was brought in by ambulance after an unwitnessed fall with scalp laceration. laceration repaired with sutures. A report to the state agency dated 8/4/24, indicated Resident (R1) was found on floor with head wound noted. Another resident (R2) was close to the scene and appeared to be leaving the area. On 8/8/24 at 11:10 a.m., video surveillance of the incident was viewed with the director of nursing (DON). The video showed R1 pushing a living room type chair across the television area of the unit. R2 was seated in a nearby chair and was speaking to R1 (no audio on video). R2 stood and began pushing the chair, with R1 still holding on to it, back across the room where it had been. As a result, R1 fell to the ground. As staff approached the area, R2 was seen talking and shaking his finger. During observation on 8/8/24 at 12:01 p.m., R1	F 600	29, 2024. To ensure compliance; an audit on resident to resident incidents will be conducted by the DON and/or designee on all resident to resident incidents to ensure appropriate assessments, interventions and monitoring occur to prevent further occurrences. All resident to resident altercations as they occur will be audited for 4 months and prn and/or as determined by quality council based on continued compliance. Audit results will be reviewed by quality council for monitoring and assured compliance. The DON is responsible for compliance. Facility will achieve substantial compliance by August 29, 2024.	

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F 600	Continued From page 4	F 600		

was ambulating in the dining room. Staff assisted her to a table in the dining and R1 got up and followed staff. R1 then sat at a table with other residents at which time staff re-directed her back to a table by herself and put food in front of her. At 12:07, R1 was up wandering in the dining room again. At 12:43, R1 was observed ambulating in the television area of the unit where she set two pieces of bread on the arm of a chair and attempted to open the door to the kitchenette.

During interview on 8/8/24 at 1:36 p.m., NA-A stated she was working the day of the 8/4/24, incident. NA-A stated she came out of another residents room and R1 was on the floor bleeding, adding she did not usually work on the unit and said she had been told R2 had pushed someone else recently and that resident had gotten seriously injured. NA-A said she had not been given any direction related to supervision of R1 or R2.

During interview on 8/8/24 at 1:48 p.m., NA-B stated on 8/4/24 she had been in another room and heard a crash and went out to assist. NA-B stated she was familiar with the residents on the unit and said the week prior R2 had pushed R1 down in the dining room. NA-B said R2 got mad when R1 was pushing chairs around and he would react. NA-B stated staff tried to re-direct R2 and tell him to go to his room but said it did not always work. NA-B stated after the incidents there were no new interventions or direction related to supervision other than to try to keep an eye on R2.

During interview on 8/8/24 at 2:06 p.m., licensed practical nurse (LPN)-A stated R2's behaviors had changed and he seemed to be getting more

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F 600	Continued From page 5	F 600		

Continued From page 5
territorial with his room and his walker. LPN-A stated R2 went through phases of going into other residents rooms and taking things. LPN-A added she was aware of the incident on 8/4/24, but was not given any specific details and when she worked, she tried to keep staff close by the residents to step in if needed. LPN-A stated R1 walked around and would pick up things to carry around with her but said R1 was not aggressive and she had never heard her raise her voice.

During interview on 8/8/24 at 2:11 p.m., NA-C stated she was on break when the 8/4/24 incident had occurred and said she also heard there had been a similar incident the week prior. NA-C said on the p.m. shift the facility had safety aides who worked and said they tried to keep and eye on the residents.

During interview on 8/8/24 at 2:32 p.m., LPN-B stated on 8/4/24 when the incident between R1 and R2 had occurred he had been called over from another unit to assist. LPN-B said R1 had fallen and sustained a head laceration. LPN-B stated staff had reported that R2 had been in the area when the fall occurred and had been hurrying away. LPN-B said R2 had other situations with residents in the past and said someone had fallen when in R2's room recently. LPN-B said there was no specific supervision plan for R2 and said staff just tried to keep an eye on him.

During interview on 8/8/24 at 3:41 p.m., the DON acknowledged R2 had been involved in other resident to resident altercations and said they had placed a stop sign on his door because he was triggered by others wandering into this room. The DON stated they had recently ordered a different

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F 600	Continued From page 6	F 600		

type of screen for R2's room. In regard to the incident on 8/4/24, DON stated the facility investigated and did not feel R2 had pushed R1 and did not intend to harm her. The DON said she felt R2 was only pushing the chair back to where it had come from. The DON said staff were monitoring R2 more closely since the incident but was not able to state what that meant and said she would have to talk with registered nurse (RN)-A. The DON further stated she was not aware R2 had pushed someone on 8/1/24.

During interview on 8/8/24 at 4:01 p.m., RN-A stated she had written the progress note on 8/1/24, when R2 had pushed another resident and said the other resident was R1. RN-A said no one had witnessed the incident on 8/4/24 until the video surveillance had been reviewed. RN-A said R2 was not on one to one supervision but staff we really trying to keep an eye on him. RN-A stated after the incident on 8/4/24, nothing new had been implemented in regard to supervision.

Facility policy Abuse Prevention Plan dated 9/5/19, identified abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish and described "Willful": the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The policy indicated once suspected abuse, neglect, misappropriation of resident property, and/or financial exploitation has been identified, safety measures will be implemented to ensure the safety of the suspected vulnerable adult and other residents. Such safety measures may include the following: Responding immediately to protect the resident or alleged victim from further abuse and to protect the

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 08/09/2024

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 600	Continued From page 7 integrity of the investigation, Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment as needed, Moving a resident to another room or floor, Providing increased staff supervision of resident, as needed. Take any other appropriate corrective action not specifically listed above.	F 600		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 20, 2024

Administrator
Villa St Vincent
516 Walsh Street
Crookston, MN 56716

Re: State Nursing Home Licensing Orders
Event ID: ECG411

Dear Administrator:

The above facility was surveyed on August 8, 2024 through August 9, 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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, Rapid Response
Licensing and Certification Program
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,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@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 08/09/2024

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2 000	Initial Comments	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 8/8/24 through 8/9/24, 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 orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED C 08/09/2024

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaint was reviewed: H54846644C (MN105462) with a licensing order issued at 1850 . 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 state form.	2 000		

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2 000	Continued From page 2 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		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to implement interventions to protect 2 of 2 residents (R1, R2) from resident to resident abuse when R2, who had a history of pushing other residents, initiated an altercation with R1 which resulted in R1's transport to the Emergency Department (ED) for a scalp laceration repaired with sutures. This	21850	Corrected	8/29/24

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21850	Continued From page 3	21850		

resulted in harm for R1.

Findings include:

R2's Resident Face Sheet indicated he admitted to the facility 11/3/22. R2's diagnosis included Alzheimer's disease, depression, dementia, obsessive compulsive disorder (OCD), unspecified head injury and disorientation.

R2's care plan dated 8/2/24, identified a risk for impaired psychosocial well-being due to cognitive impairment and indicated he could become aggressive toward others. The care plan further identified a risk for harming others and indicated he had been aggressive (pushed) another resident. The care plan identified the use of a stop sign on R2's door to deter others from entering and directed staff to close door when appropriate and re-direct R2 or others away if showing agitation.

R2's Observation Detail List, Behavior Conditions dated 8/2/24, identified Alzheimer's Disease, subarachnoid hemorrhage, OCD and depression. The observation indicated physical behaviors toward others occurred 1-3 of the past seven days and indicated the behaviors put others at significant risk for injury.

R2's Resident Progress Notes identified the following:
-7/25/24, R2 stated to nursing assistant (NA) he had had pushed another resident who had come into his room.
-8/1/24, R2 was seen pushing another resident that morning. When approached R2 stated, "she was taking his walker." Resident informed it was not appropriate to push residents.
-8/4/24, 1:09 p.m. R2 noted to be entering other

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21850	Continued From page 4	21850		

Continued From page 4

residents rooms. Denied when approached until staff mentioned he had been seen entering or leaving another's room.

During observation on 8/8/24 at 12:22 p.m., R2 was observed leaving the dining room. He entered his room, re-applied a Velcro stop sign to his door, and shut the door.

R1's Resident Face Sheet indicated she admitted to the facility 10/19/23. R1's diagnosis included Alzheimer's Disease, head laceration, dementia, anxiety and depression.

R1's care plan dated 7/29/24, identified inappropriate behaviors exhibited by wandering into other residents rooms, taking things and becoming defensive/combative with directions. The care plan indicated R1 was unaware of personal boundaries and property and did not appear to comprehend direction. The care plan directed if R1 was wandering in potentially dangerous area or near residents known for agitation/aggression to escort away and provide diversional activity. The care plan further indicated she had been a victim of another resident's physical aggression.

R1's Resident Progress Notes indicated the following:
-8/4/24, 1:30 p.m. R1 was attempting to push residents around in their wheelchairs multiple times. Redirection attempted without success.
-8/4/24, 4:37 p.m. R1 was found lying on her back on the floor in the common area with a pool of blood under her head. R1 complained of pain to her coccyx. Sent to ED.

R1's ED visit note dated 8/4/24, indicated she was brought in by ambulance after an

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unwitnessed fall with scalp laceration. laceration repaired with sutures.

A report to the state agency dated 8/4/24, indicated Resident (R1) was found on floor with head wound noted. Another resident (R2) was close to the scene and appeared to be leaving the area.

On 8/8/24 at 11:10 a.m., video surveillance of the incident was viewed with the director of nursing (DON). The video showed R1 pushing a living room type chair across the television area of the unit. R2 was seated in a nearby chair and was speaking to R1 (no audio on video). R2 stood and began pushing the chair, with R1 still holding on to it, back across the room where it had been. As a result, R1 fell to the ground. As staff approached the area, R2 was seen talking and shaking his finger.

During observation on 8/8/24 at 12:01 p.m., R1 was ambulating in the dining room. Staff assisted her to a table in the dining and R1 got up and followed staff. R1 then sat at a table with other residents at which time staff re-directed her back to a table by herself and put food in front of her. At 12:07, R1 was up wandering in the dining room again. At 12:43, R1 was observed ambulating in the television area of the unit where she set two pieces of bread on the arm of a chair and attempted to open the door to the kitchenette.

During interview on 8/8/24 at 1:36 p.m., NA-A stated she was working the day of the 8/4/24, incident. NA-A stated she came out of another residents room and R1 was on the floor bleeding, adding she did not usually work on the unit and said she had been told R2 had pushed someone else recently and that resident had gotten

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seriously injured. NA-A said she had not been given any direction related to supervision of R1 or R2.

During interview on 8/8/24 at 1:48 p.m., NA-B stated on 8/4/24 she had been in another room and heard a crash and went out to assist. NA-B stated she was familiar with the residents on the unit and said the week prior R2 had pushed R1 down in the dining room. NA-B said R2 got mad when R1 was pushing chairs around and he would react. NA-B stated staff tried to re-direct R2 and tell him to go to his room but said it did not always work. NA-B stated after the incidents there were no new interventions or direction related to supervision other than to try to keep an eye on R2.

During interview on 8/8/24 at 2:06 p.m., licensed practical nurse (LPN)-A stated R2's behaviors had changed and he seemed to be getting more territorial with his room and his walker. LPN-A stated R2 went through phases of going into other residents rooms and taking things. LPN-A added she was aware of the incident on 8/4/24, but was not given any specific details and when she worked, she tried to keep staff close by the residents to step in if needed. LPN-A stated R1 walked around and would pick up things to carry around with her but said R1 was not aggressive and she had never heard her raise her voice.

During interview on 8/8/24 at 2:11 p.m., NA-C stated she was on break when the 8/4/24 incident had occurred and said she also heard there had been a similar incident the week prior. NA-C said on the p.m. shift the facility had safety aides who worked and said they tried to keep and eye on the residents.

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21850	Continued From page 7 During interview on 8/8/24 at 2:32 p.m., LPN-B stated on 8/4/24 when the incident between R1 and R2 had occurred he had been called over from another unit to assist. LPN-B said R1 had fallen and sustained a head laceration. LPN-B stated staff had reported that R2 had been in the area when the fall occurred and had been hurrying away. LPN-B said R2 had other situations with residents in the past and said someone had fallen when in R2's room recently. LPN-B said there was no specific supervision plan for R2 and said staff just tried to keep an eye on him. During interview on 8/8/24 at 3:41 p.m., the DON acknowledged R2 had been involved in other resident to resident altercations and said they had placed a stop sign on his door because he was triggered by others wandering into this room. The DON stated they had recently ordered a different type of screen for R2's room. In regard to the incident on 8/4/24, DON stated the facility investigated and did not feel R2 had pushed R1 and did not intend to harm her. The DON said she felt R2 was only pushing the chair back to where it had come from. The DON said staff were monitoring R2 more closely since the incident but was not able to state what that meant and said she would have to talk with registered nurse (RN)-A. The DON further stated she was not aware R2 had pushed someone on 8/1/24. During interview on 8/8/24 at 4:01 p.m., RN-A stated she had written the progress note on 8/1/24, when R2 had pushed another resident and said the other resident was R1. RN-A said no one had witnessed the incident on 8/4/24 until the video surveillance had been reviewed. RN-A said R2 was not on one to one supervision but staff we really trying to keep an eye on him. RN-A	21850		

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21850	Continued From page 8 stated after the incident on 8/4/24, nothing new had been implemented in regard to supervision. Facility policy Abuse Prevention Plan dated 9/5/19, identified abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish and described "Willful": the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The policy indicated once suspected abuse, neglect, misappropriation of resident property, and/or financial exploitation has been identified, safety measures will be implemented to ensure the safety of the suspected vulnerable adult and other residents. Such safety measures may include the following: Responding immediately to protect the resident or alleged victim from further abuse and to protect the integrity of the investigation, Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment as needed, Moving a resident to another room or floor, Providing increased staff supervision of resident, as needed. Take any other appropriate corrective action not specifically listed above. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise policies or procedures to ensure appropriate interventions and oversight is provided to prevent further abuse or neglect from occurring. The facility could audit all complaints of abuse or neglect to ensure appropriate assessments, interventions, and monitoring occur to prevent further abuse or neglect and educate all staff on those policies. The results of those audits could be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further	21850		

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21850	Continued From page 9 monitoring. TIME PERIOD FOR CORRECTION: 21 DAYS	21850		