DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 10, 2023

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

RE: CCN: 245484
Cycle Start Date: December 21, 2022

Dear Administrator:

On December 21, 2022, a survey was completed at your facility by the Minnesota Departments of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

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

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

If substantial compliance with the regulations is not verified by March 21, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 21, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245484	A. BUILDING _____ B. WING _____	C 12/21/2022

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 12/20/22-12/21/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H54846997C (MN88428), however, NO deficiencies were cited due to actions implemented by the facility prior to survey. However, as a result of the investigation, a deficiency was cited at F686 and F604. The following complaint was found to be UNSUBSTANTIATED: H54846738C (MN89299). 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 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:	F 604		1/31/23

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

Electronically Signed | 01/20/2023

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 604	Continued From page 1 §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 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. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify a Broda chair (brand of wheel chairs with a high back that can be reclined typically used for positioning and pressure reducing, and do not allow for independent mobility) as a restraint for 1 of 1 residents (R3) reviewed for restraints. In addition, the facility failed to trial a less restrictive wheelchair upon request of R3 and his family member (FM)-A.	F 604	F604 Right to be Free from Physical Restraints: This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and	

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F 604	Continued From page 2 Findings include: R3's quarterly Minimum Data Set (MDS) dated 9/15/22, indicated he was moderately cognitively impaired and did not display any behaviors. The MDS indicated R3 required extensive assistance from two staff for bed mobility, transfer and toileting, and was frequently incontinent of bowel and bladder. R3's care plan dated 12/20/22, identified a self care deficit and directed staff to provide extensive assistance for activities of daily living. The care plan further identified a risk for falls and indicated interventions that included putting shoes in closet, putting laundry away and out of site and a body pillow while in bed. The care plan dated 11/11/22, indicated R3 used the wheelchair for mobility. Facility Progress Notes (PN) indicated R3 had multiple falls in the facility. -On 11/1/22, R3 was observed on the floor in his room. R3 stated he was trying to get into his wheelchair. -On 11/19/22, R3 was found seated on the floor in his room with his back against the door and stated he hit his jaw on his wheel chair. A note dated 11/20/22, indicated R3 fell the previous day attempting to get up from his wheel chair. -On 11/28/22, R3 was found seated on the floor in front of his night stand and said he was trying to put his shoes on. R3 had been incontinent. -On 12/1/22, R3 fell in his bathroom attempting to self-transfer from the toilet after being left unattended by staff. -On 12/4/22, R3 fell in his room and said he was trying to get his clothes off the hanger. -On 12/8/22, R3 was found on his stomach on the floor and stated he was trying to reach his shoes.	F 604	state law requirements. 1.Corrective Action for Resident Affected: R3 was assessed for and provided a different wheelchair to trial. Resident and family satisfied with change and wheelchair. IDT reviewed and amended fall interventions. 2. Actions as it applies to others: All residents that are utilizing Broda chairs were evaluated for appropriateness by IDT. 3. Measures put into place to prevent further issues: The Restraint policy was reviewed. Staff educated on restraint policy and Broda use. Broda assessment and consent created to be completed prior to Broda wheel chair use. 4. How the facility will monitor: To ensure continued compliance, the DON or designee will audit residents who have initiated use of Broda wheelchairs have the Broda assessment completed and consent from resident or family be given. Audit results will be reviewed monthly with QAPI and continued audits will be completed until 100% compliance achieved for 3 consecutive months.	

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F 604	Continued From page 3 Care planned interventions included putting R3's shoes in the closet and putting laundry out of site, rather than placing items where R3 had access to them. A facility PN dated 12/8/22, indicated family member (FM)-A called writer regarding wanting a trial use of R3's old wheelchair so he could be more mobile. FM-A stated R3 had requested the chair and she felt giving it another trial would be beneficial for him and stated, "He has lost so much freedom and independence in the last few months." Writer informed FM-A of previous falls using the old wheel chair and told her the current wheelchair was appropriate for R3. FM-A verbalized understanding however, had still requested to give it a trial despite teachings provided. Writer told FM-A she would speak to the unit manager and interdisciplinary team (IDT) for their opinions. During observation on 12/21/22, at 7:52 a.m. R3 was seated in a common area of the facility in a Broda chair with foot pedals. R3 was pushed up to a table with a newspaper in front of him. At 8:25 a.m. staff assisted R3 to the dining table where he ate breakfast. At 9:08 a.m. R3 was observed at the dining room table with his chair reclined back. On 12/21/22, at 9:35 a.m. R3 was interviewed with FM-A. FM-A stated R3 had a lot of falls since he admitted to the facility, and stated he had fallen a lot at home prior to admission. FM-A stated R3 wanted to do things for himself. FM-A stated the first two days in the facility R3 had a standard wheelchair then the facility had placed him in a Broda chair. FM-A stated, "He hates this one." FM-A said she had asked the facility to give	F 604		

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F 604	Continued From page 4	F 604		

the other wheelchair a try again and they told her they had given him the Broda chair because of his falls. FM-A stated the facility had not given her a definite answer and had not done anything about it and said, "I just sincerely wish they would give him [R3] another chance" which R3 indicated he agreed. FM-A further stated, "I feel like this really restricts his movement." In regard to R3's falls, FM-A stated she was at the facility about every 3-4 days and said when she is not here the call light is not in reach, and if R3 could not get hold of the staff to use the bathroom, he would try to do it himself.

During interview on 12/21/22, at 10:43 p.m. licensed practical nurse (LPN)-B stated R3 was confused and often when he fell it was because he was trying to get into his chair or reaching for shoes. LPN-B stated the Broda chair was to remind him he could not get up on his own.

On 12/21/22, at 10:46 a.m. nursing assistant (NA)-C stated R3 needed assistance to propel in the Broda chair and was not able to propel himself around once in the Broda chair.

On 12/21/22, at 2:03 p.m. registered nurse (RN)-B stated R3 had sustained multiple falls in the facility and prior to admission. RN-B stated R3 did not have a full grasp of his limitations, and he knew he was not supposed to transfer himself. RN-B stated FM-A had told her R3 had always been independent. RN-B stated when R3 admitted to the facility he had his personal wheel chair which she did not feel was appropriate. RN-B stated R3 did not look comfortable in the chair. RN-B stated R3 was stubborn, wanted to be independent, and propelled himself and used his legs in the wheelchair. RN-B stated that was a

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F 604	Continued From page 5 concern for her. RN-B stated she felt like R3 was going to tip or slide off of the wheel chair. RN-B stated they put R3 in the Broda chair and he looked and felt comfortable, so that was what he had been using. RN-B acknowledged no other type of wheel chair had been assessed or tried. RN-B stated FM-A had called and asked to trial R3 back in his old wheelchair. RN-B stated she had discussed her concerns with FM-B regarding R3's falls. RN-B stated FM-B told her R3 was not as mobile as he used to be when he was in the Broda chair. RN-B stated it had not been discussed since the Broda chair was implemented, although a PN written by RN-B indicated the interdisciplinary team would review. When asked why she felt R3 was self transferring, RN-B stated sometimes he would say he needed to use the bathroom and sometimes the call light was not in reach. Facility policy Chemical and Physical Restraints dated 2020, directed residents are provided services to attain and maintain the highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience, and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints. Physical restraints include, but are not limited to: leg restraints, arm restraints, hand mitts, soft ties or vests, lap cushions and lap trays the resident cannot remove. Also included as restraints are facility practices that meet the definition of a restraint, such as placing a resident in a chair that prevents a resident from rising.	F 604		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		1/31/23

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F 686	Continued From page 6 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement person centered interventions to reduce the risk for pressure ulcers and failed to complete thorough assessments of pressure ulcers for 1 of 1 residents (R2) reviewed who developed pressure ulcers in the facility. Findings include: R2's Resident Face Sheet indicated she admitted to the facility on 11/9/22, with diagnosis that included encounter for palliative care, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety and weakness. R2's admission Minimum Data Set (MDS) dated 11/16/22, identified severe cognitive impairment and indicated she required extensive assistance of two staff for bed mobility, transfers and toileting. The MDS identified a risk for pressure ulcers, and indicated R1 did not have a pressure	F 686	F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. 1. Corrective Action for Resident Affected: Full skin assessment completed on R2. Wounds measured and staged and documented in medical record. Care plan updated for additional pressure relieving measures. Appropriate notifications made to hospice and MD. 2. Actions as it applies to others: Identified residents at risk for unidentified skin	

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F 686	Continued From page 7 ulcer at the time of the assessment. The MDS identified moisture associated skin damage (MASD) at the time of the assessment. R2's care plan dated 11/10/22, identified a self care deficit and directed staff to provide assistance of two staff for bed mobility, transfers and toileting. The care plan further identified bowel and bladder incontinence and directed staff to provide physical assistance for toileting. The care plan directed staff to report signs of skin breakdown to include sore, tender, red or broken areas, and provide moisture barrier to skin following incontinence care. The care plan lacked interventions specific to R2's wound(s). A Skin Risk Assessment dated 11/9/22, indicated R2 had a pressure ulcer, and indicated perineal area was red and blanchable. The assessment lacked further description, stage or size of the wound. The assessment identified a Braden score of 12 indicating R2 was at high risk for developing pressure ulcers. The assessment indicated R2 appeared confused and mainly non-verbal. R2 gestured when asked about pain and pointed and rubbed toward her buttocks. The assessment indicated R2 was incontinent of bowel and bladder. Skin: she was reported to have redness to her coccyx and buttocks and motioned discomfort to buttocks. Using calmoseptine to area. Repositioning was effective. Full skin assessment to be completed. A Skin Risk Assessment dated 11/16/22, indicated R2 did not have a pressure ulcer. R2's facility Progress Notes (PN) identified the following:	F 686	issues based upon IDT team input including Braden score of 15 or less. These residents had additional initial visual skin assessments completed. No new pressure injuries identified. Residents with previously identified pressure ulcers audited for appropriate staging and interventions. 3. Measures put into place to prevent further issues: Education provided to staff on prompt notification of any skin integrity issues. Education provided to ensure full visualization of skin during weekly skin observation. 4. How the facility will monitor: To ensure continued compliance, audits will be conducted by DON/DON designee weekly on a sample of 10 charts/week for policy compliance related to Braden frequency, completion of skin observation notes, and initiation of appropriate interventions when indicated by either Braden risk score or identification of skin integrity impairments. Audit results will be reviewed monthly with QAPI and continued audits will be completed until 100% compliance has been achieved for 3 consecutive months.	

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F 686	Continued From page 8 -11/23/22, R2 had "popped" blister to her right outer thigh where lift sheet sits. No drainage, area very dry, skin protectant applied. -11/30/22, Writer was called into R2's room by nursing assistant (NA) and reported bruising to R2's left outer thigh measuring 7 centimeters (cm) x 5 cm. The bruising was light red to the outer and a little dark red toward the center. -12/1/22, Skin: reddened area to left outer thigh appeared to be related to where sling may rub on skin during transfer and repositioning in bed with transfer sheet causing shearing. 12/4/22, Area on left thigh dressing changed, area drying well, new dressing applied. R2's PNs and Assessments lacked evidence of staging, description of characteristics, surrounding tissue or progress toward healing. During observation on 12/21/22, at 12:40 p.m. nursing assistant (NA)-A, NA-B, and licensed practical nurse (LPN)-A assisted R2 from her wheel chair to her bed using a mechanical lift. R2 was observed with the lift sling underneath her while seated in the wheel chair. NA-A and NA-B removed the sling from underneath R2 and assisted to provide personal cares. LPN-A removed a bandage from R2's left thigh that had a small amount of bloody drainage on it, revealing a red area approximately six inches long and 2.5 inches wide. The area had two separate open areas approximately quarter sized and a creased area approximately 3 inches long.. NA-A and NA-B rolled R2 to her side and revealed a wound to R2's coccyx which LPN-A described as pink, slightly macerated with two separate round areas	F 686		

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(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 686	Continued From page 9 and a blister. LPN-A stated she would have registered nurse (RN)-A complete a thorough assessment. During interview on 12/21/22, at 1:12 p.m. RN-A stated she had assessed R2's skin following surveyor observation. RN-A stated R2's coccyx area appeared to be a Stage I deep tissue injury, and stated the wound measured 4.2 cm x 2 cm. RN-A described the wound as dark rust and purplish in color. RN-A described the skin around the coccyx "dimple" as a darker purple and indicated within the area was an open "slit" measuring 7 cm x 2 cm with no drainage. RN-A stated the initial blister on R2's right thigh indicated she had pressure. Regarding the wound on R2's left thigh, RN-A stated it initially started as a result of shearing believed to be from the lift sheet. RN-A stated the last skin assessment had been completed the previous day however acknowledged the assessment was not accurate as skin had been described as intact. RN-A stated skin assessments were supposed to be completed weekly on bath days. RN-A further acknowledged R2's care plan indicated her skin would remain intact but lacked specific interventions related to R2's current skin condition and/or cause of the wounds. During interview on 11/22/22, at approximately 1:30 p.m. the director of nursing (DON) stated upon identification of R2's initial skin concern staff should have established a skin care plan to include repositioning and moisture care. The DON further stated weekly follow up assessments should have been conducted. Facility policy Prevention and Treatment of Skin Breakdown dated 2018, directed resident skin	F 686		

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	245484	A. BUILDING _____ B. WING _____	C 12/21/2022

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F 686	Continued From page 10 integrity is assessed upon admission and weekly thereafter. A skin risk assessment is completed upon admission and weekly for four weeks upon significant change, and quarterly thereafter. Those residents at an increased risk for impaired skin integrity are provided preventative measures to reduce the potential for skin breakdown. Those residents' who experience a break in skin integrity or wounds are provided care and service to heal the skin according to professional standards of care. When pressure injury is present, the dressing and/or wound is monitored, as appropriate. Weekly the licensed nurse will stage, measure, and examine the wound bed and surrounding skin. If wound bed has deteriorated; notify provider. A resident centered care plan is implemented/updated for skin risk with interventions based upon: areas of risk, resident assessment, Braden evaluation score of 15 or less, clinicians assessment/evaluation and resident preferences.	F 686		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 10, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: 6V5111

Dear Administrator:

The above facility was surveyed on December 21, 2022 through December 21, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00815	A. BUILDING: _____ B. WING _____	C 12/21/2022

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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 12/20/22 - 12/21/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H54846997C (MN88428) with no licensing order issued. However, as a result of the investigation, a licensing orders were issued at 0900 and 0510 . The following complaint was found to be UNSUBSTANTIATED: H54846738C (MN89299). 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	2 000		

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2 000	Continued From page 2 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 510	MN Rule 4658.0300 Subp. 2 Use of Restraints Subp. 2. Freedom from restraints. Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify a Broda chair (brand of wheel chairs with a high back that can be reclined typically used for positioning and pressure reducing, and do not allow for independent mobility) as a restraint for 1 of 1 residents (R3) reviewed for restraints. In addition, the facility failed to trial a less restrictive wheelchair upon request of R3 and his family member (FM)-A. Findings include: R3's quarterly Minimum Data Set (MDS) dated 9/15/22, indicated he was moderately cognitively impaired and did not display any behaviors. The MDS indicated R3 required extensive assistance	2 510	corrected	1/31/23

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2 510	Continued From page 3 from two staff for bed mobility, transfer and toileting, and was frequently incontinent of bowel and bladder. R3's care plan dated 12/20/22, identified a self care deficit and directed staff to provide extensive assistance for activities of daily living. The care plan further identified a risk for falls and indicated interventions that included putting shoes in closet, putting laundry away and out of site and a body pillow while in bed. The care plan dated 11/11/22, indicated R3 used the wheelchair for mobility. Facility Progress Notes (PN) indicated R3 had multiple falls in the facility. -On 11/1/22, R3 was observed on the floor in his room. R3 stated he was trying to get into his wheelchair. -On 11/19/22, R3 was found seated on the floor in his room with his back against the door and stated he hit his jaw on his wheel chair. A note dated 11/20/22, indicated R3 fell the previous day attempting to get up from his wheel chair. -On 11/28/22, R3 was found seated on the floor in front of his night stand and said he was trying to put his shoes on. R3 had been incontinent. -On 12/1/22, R3 fell in his bathroom attempting to self-transfer from the toilet after being left unattended by staff. -On 12/4/22, R3 fell in his room and said he was trying to get his clothes off the hanger. -On 12/8/22, R3 was found on his stomach on the floor and stated he was trying to reach his shoes. Care planned interventions included putting R3's shoes in the closet and putting laundry out of site, rather than placing items where R3 had access to them. A facility PN dated 12/8/22, indicated family member (FM)-A called writer regarding wanting a	2 510		

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2 510	Continued From page 4 trial use of R3's old wheelchair so he could be more mobile. FM-A stated R3 had requested the chair and she felt giving it another trial would be beneficial for him and stated, "He has lost so much freedom and independence in the last few months." Writer informed FM-A of previous falls using the old wheel chair and told her the current wheelchair was appropriate for R3. FM-A verbalized understanding however, had still requested to give it a trial despite teachings provided. Writer told FM-A she would speak to the unit manager and interdisciplinary team (IDT) for their opinions. During observation on 12/21/22, at 7:52 a.m. R3 was seated in a common area of the facility in a Broda chair with foot pedals. R3 was pushed up to a table with a newspaper in front of him. At 8:25 a.m. staff assisted R3 to the dining table where he ate breakfast. At 9:08 a.m. R3 was observed at the dining room table with his chair reclined back. On 12/21/22, at 9:35 a.m. R3 was interviewed with FM-A. FM-A stated R3 had a lot of falls since he admitted to the facility, and stated he had fallen a lot at home prior to admission. FM-A stated R3 wanted to do things for himself. FM-A stated the first two days in the facility R3 had a standard wheelchair then the facility had placed him in a Broda chair. FM-A stated, "He hates this one." FM-A said she had asked the facility to give the other wheelchair a try again and they told her they had given him the Broda chair because of his falls. FM-A stated the facility had not given her a definite answer and had not done anything about it and said, "I just sincerely wish they would give him [R3] another chance" which R3 indicated he agreed. FM-A further stated, "I feel like this really restricts his movement." In regard to R3's	2 510		

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2 510	Continued From page 5 falls, FM-A stated she was at the facility about every 3-4 days and said when she is not here the call light is not in reach, and if R3 could not get hold of the staff to use the bathroom, he would try to do it himself. During interview on 12/21/22, at 10:43 p.m. licensed practical nurse (LPN)-B stated R3 was confused and often when he fell it was because he was trying to get into his chair or reaching for shoes. LPN-B stated the Broda chair was to remind him he could not get up on his own. On 12/21/22, at 10:46 a.m. nursing assistant (NA)-C stated R3 needed assistance to propel in the Broda chair and was not able to propel himself around once in the Broda chair. On 12/21/22, at 2:03 p.m. registered nurse (RN)-B stated R3 had sustained multiple falls in the facility and prior to admission. RN-B stated R3 did not have a full grasp of his limitations, and he knew he was not supposed to transfer himself. RN-B stated FM-A had told her R3 had always been independent. RN-B stated when R3 admitted to the facility he had his personal wheel chair which she did not feel was appropriate. RN-B stated R3 did not look comfortable in the chair. RN-B stated R3 was stubborn, wanted to be independent, and propelled himself and used his legs in the wheelchair. RN-B stated that was a concern for her. RN-B stated she felt like R3 was going to tip or slide off of the wheel chair. RN-B stated they put R3 in the Broda chair and he looked and felt comfortable, so that was what he had been using. RN-B acknowledged no other type of wheel chair had been assessed or tried. RN-B stated FM-A had called and asked to trial R3 back in his old wheelchair. RN-B stated she had discussed her concerns with FM-B regarding	2 510		

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2 510	Continued From page 6 R3's falls. RN-B stated FM-B told her R3 was not as mobile as he used to be when he was in the Broda chair. RN-B stated it had not been discussed since the Broda chair was implemented, although a PN written by RN-B indicated the interdisciplinary team would review. When asked why she felt R3 was self transferring, RN-B stated sometimes he would say he needed to use the bathroom and sometimes the call light was not in reach. Facility policy Chemical and Physical Restraints dated 2020, directed residents are provided services to attain and maintain the highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience, and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints. Physical restraints include, but are not limited to: leg restraints, arm restraints, hand mitts, soft ties or vests, lap cushions and lap trays the resident cannot remove. Also included as restraints are facility practices that meet the definition of a restraint, such as placing a resident in a chair that prevents a resident from rising. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review all residents who are in a restraint. The DON or designee could review and revise policies and procedures relating to restraints. The DON or designee could conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development, and bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to	2 510		

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2 510	Continued From page 7 determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 510		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to implement person centered interventions to reduce the risk for pressure ulcers and failed to complete thorough assessments of pressure ulcers for 1 of 1 residents (R2) reviewed who developed pressure ulcers in the facility. Findings include:	2 900	corrected	1/31/23

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2 900	Continued From page 8 R2's Resident Face Sheet indicated she admitted to the facility on 11/9/22, with diagnosis that included encounter for palliative care, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety and weakness. R2's admission Minimum Data Set (MDS) dated 11/16/22, identified severe cognitive impairment and indicated she required extensive assistance of two staff for bed mobility, transfers and toileting. The MDS identified a risk for pressure ulcers, and indicated R1 did not have a pressure ulcer at the time of the assessment. The MDS identified moisture associated skin damage (MASD) at the time of the assessment. R2's care plan dated 11/10/22, identified a self care deficit and directed staff to provide assistance of two staff for bed mobility, transfers and toileting. The care plan further identified bowel and bladder incontinence and directed staff to provide physical assistance for toileting. The care plan directed staff to report signs of skin breakdown to include sore, tender, red or broken areas, and provide moisture barrier to skin following incontinence care. The care plan lacked interventions specific to R2's wound(s). A Skin Risk Assessment dated 11/9/22, indicated R2 had a pressure ulcer, and indicated perineal area was red and blanchable. The assessment lacked further description, stage or size of the wound. The assessment identified a Braden score of 12 indicating R2 was at high risk for developing pressure ulcers. The assessment indicated R2 appeared confused and mainly non-verbal. R2 gestured when asked about pain and pointed and rubbed toward her buttocks. The assessment indicated R2 was incontinent of	2 900		

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2 900	Continued From page 9 bowel and bladder. Skin: she was reported to have redness to her coccyx and buttocks and motioned discomfort to buttocks. Using calmoseptine to area. Repositioning was effective. Full skin assessment to be completed. A Skin Risk Assessment dated 11/16/22, indicated R2 did not have a pressure ulcer. R2's facility Progress Notes (PN) identified the following: -11/23/22, R2 had "popped" blister to her right outer thigh where lift sheet sits. No drainage, area very dry, skin protectant applied. -11/30/22, Writer was called into R2's room by nursing assistant (NA) and reported bruising to R2's left outer thigh measuring 7 centimeters (cm) x 5 cm. The bruising was light red to the outer and a little dark red toward the center. -12/1/22, Skin: reddened area to left outer thigh appeared to be related to where sling may rub on skin during transfer and repositioning in bed with transfer sheet causing shearing. 12/4/22, Area on left thigh dressing changed, area drying well, new dressing applied. R2's PNs and Assessments lacked evidence of staging, description of characteristics, surrounding tissue or progress toward healing. During observation on 12/21/22, at 12:40 p.m. nursing assistant (NA)-A, NA-B, and licensed practical nurse (LPN)-A assisted R2 from her wheel chair to her bed using a mechanical lift. R2 was observed with the lift sling underneath her while seated in the wheel chair. NA-A and NA-B	2 900		

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 12/21/2022

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
2 900	Continued From page 10 removed the sling from underneath R2 and assisted to provide personal cares. LPN-A removed a bandage from R2's left thigh that had a small amount of bloody drainage on it, revealing a red area approximately six inches long and 2.5 inches wide. The area had two separate open areas approximately quarter sized and a creased area approximately 3 inches long.. NA-A and NA-B rolled R2 to her side and revealed a wound to R2's coccyx which LPN-A described as pink, slightly macerated with two separate round areas and a blister. LPN-A stated she would have registered nurse (RN)-A complete a thorough assessment. During interview on 12/21/22, at 1:12 p.m. RN-A stated she had assessed R2's skin following surveyor observation. RN-A stated R2's coccyx area appeared to be a Stage I deep tissue injury, and stated the wound measured 4.2 cm x 2 cm. RN-A described the wound as dark rust and purplish in color. RN-A described the skin around the coccyx "dimple" as a darker purple and indicated within the area was an open "slit" measuring 7 cm x 2 cm with no drainage. RN-A stated the initial blister on R2's right thigh indicated she had pressure. Regarding the wound on R2's left thigh, RN-A stated it initially started as a result of shearing believed to be from the lift sheet. RN-A stated the last skin assessment had been completed the previous day however acknowledged the assessment was not accurate as skin had been described as intact. RN-A stated skin assessments were supposed to be completed weekly on bath days. RN-A further acknowledged R2's care plan indicated her skin would remain intact but lacked specific interventions related to R2's current skin condition and/or cause of the wounds.	2 900		

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2 900	Continued From page 11 During interview on 11/22/22, at approximately 1:30 p.m. the director of nursing (DON) stated upon identification of R2's initial skin concern staff should have established a skin care plan to include repositioning and moisture care. The DON further stated weekly follow up assessments should have been conducted. Facility policy Prevention and Treatment of Skin Breakdown dated 2018, directed resident skin integrity is assessed upon admission and weekly thereafter. A skin risk assessment is completed upon admission and weekly for four weeks upon significant change, and quarterly thereafter. Those residents at an increased risk for impaired skin integrity are provided preventative measures to reduce the potential for skin breakdown. Those residents' who experience a break in skin integrity or wounds are provided care and service to heal the skin according to professional standards of care. When pressure injury is present, the dressing and/or wound is monitored, as appropriate. Weekly the licensed nurse will stage, measure, and examine the wound bed and surrounding skin. If wound bed has deteriorated; notify provider. A resident centered care plan is implemented/updated for skin risk with interventions based upon: areas of risk, resident assessment, Braden evaluation score of 15 or less, clinicians assessment/evaluation and resident preferences. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a	2 900		

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2 900	Continued From page 12 specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		