Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 25, 2025

Administrator
Villa St Vincent
516 WALSH STREET
CROOKSTON, MN 56716

RE: CCN: 245484
Cycle Start Date:

Dear Administrator:

On [First State Notice Date()], we informed you that we may impose enforcement remedies.

On July 10, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

This survey also found other 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),whereby corrections are required.

REMEDIES

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

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

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

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

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

• Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

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

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 9, 2025. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

DEPARTMENT CONTACT

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

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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.

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 10, 2026 (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:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written

request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

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

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

INFORMAL DISPUTE RESOLUTION (IDR)
In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Vincent	516 WALSH STREET , CROOKSTON, Minnesota, 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
F0000	INITIAL COMMENTS On 7/9/25 through 7/10/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H54848767C (MN00114350, MN00114544) was reviewed with a deficiency cited at F760. H54849049C (MN00114300) was reviewed with a deficiency cited at F600. As a result of the survey a deficiency was cited at F609. 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.	F0000		08/06/2025
F0600 SS = D	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.	F0600	During the survey process it was noted that the facility failed to implement interventions to protect the residents rights of 2 residents and monitor resident for mood & behavioral changes. Steps taken to protect R2-The daily staffing schedule has been adjusted to clearly identify the designated associate assigned to provide supervision of the specified resident. Staff have been educated to keep eyes on R2 to allow safe wandering, intervene with distraction/redirection when in close proximity of other resident rooms or other residents personal space. Associates are to clearly communicate when the supervision responsibility is transferred to another associate. Speech Therapy attempted to complete an	08/06/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Vincent	516 WALSH STREET , CROOKSTON, Minnesota, 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
F0600 SS = D	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 protect the residents right to be free from physical abuse by other residents for 2 of 3 residents (R2, R3) when care plan intervention to adequately increase supervision to protect residents from abuse were not implemented and behaviors were not investigated or documented with detail to assist in determining possible antecedents of the negative behavior. Additionally, the facility failed to monitor R3 for mood and behavioral changes following a resident-to-resident abuse incident which resulted in minor injuries and increased withdrawal. R2's Resident Face Sheet indicated she admitted to the facility 10/19/23. R2's diagnosis included Alzheimer's disease, insomnia and dementia with behavioral disturbance. R2's quarterly Minimum Data Set (MDS) dated 4/10/25, identified severe cognitive impairment and indicated she displayed wandering behaviors 4-6 days during the assessment period. The MDS indicated R2 ambulated independently. R2's Vulnerable Adult assessment dated 10/24/24, indicated she did not have a history of abuse toward others or self abuse. R2 had physical limitations and cognitive deficits that made her susceptible to abuse. R2 had behaviors that made her susceptible to abuse to self or others and had communication limitations. R2's care plan dated 6/30/25, identified her as a vulnerable adult and indicated if she became violent or aggressive staff should implement interventions to minimized risk to herself or others. The care plan indicated she had exhibited physical aggression toward others and indicated she had slapped another resident on 10/4/24 and 10/11/24, had pinched another resident on 10/6/24, and pushed another resident on 6/30/25. The care plan directed staff to provide close supervision and gently guide her away if she was observed in close proximity to peers, especially when entering others personal space or rooms and observe her closely to identify specific triggers that may lead to aggression.	F0600	Continued from page 1 evaluation with R2 further, all attempts unsuccessful. The social services associate continues to seek alternative placement that may be better suited for R2. The care plan for R2 was reviewed and updated on 7/31/25. Steps taken to protect R3- A Velcro stop sign was placed across her door way to detour others from entering her room until a Velcro mesh screen could be applied to the exterior of her door frame. RN unit manager and social services have observed and interviewed R3 regarding mood and behaviors. Staff interviews were conducted and record review to determine the residents baseline activity. During this, it was identified this residents mood and activity baseline does fluctuate from time to time. There are times she is out and about throughout the unit but she does tend to spend more time in her room. At other times she spends the majority of her time in her room. R3's care plan has been updated to reflect this. Steps taken to protect others- Education will be provide to all associates of the importance of monitoring and reporting new and or repetitive actions that place the resident or others at risk for harm to devise a plan for clear supervision. Additionally, we will set up monitoring of resident's mood / behavior after any resident to resident altercations to ensure changes are identified. The social services staff will meet with the resident following the incident to identify changes and report to UM. All information will be reviewed by the unit manager to ensure any changes from baseline have been identified and addressed in a timely manner. All residents have the ability to be affected by resident to resident altercations. Any residents who display mood and behavior changes within the last 30 days will be have their care plans reviewed for appropriate interventions to deter from resident to resident altercations by 7/31/25. Facility policy on behavioral expressions was reviewed and no revisions were made on 7/30/2025. Facility nursing staff will be educated on the behavioral expressions policy on or before 8/6/2025. Audits will be conducted on 5 residents randomly selected that exhibit behavioral or mood changes to ensure proper supervision and interventions are in place for the safety of themselves and others per week x 4 weeks. Then the audits will go down to 3 residents per week x 8 weeks and as needed thereafter as determined by quality council for continued compliance. DON/DON designee are responsible for compliance. Compliance date 8/6/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Vincent	516 WALSH STREET , CROOKSTON, Minnesota, 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
F0600 SS = D	Continued from page 2 The care plan further directed staff to provide sensory items and/or baby doll and stroller when R2 became agitated. The care plan indicated R2 exhibited inappropriate behaviors such as wandering into other residents rooms and taking things that didn't belong to her. R2's Resident Progress Notes identified the following: 5/11/25, R2 had family visit. After they left R2 appeared to be upset. R2 had been in and out of other residents rooms, tried to take a blanket off someone who was using it and was walking around the dining room trying to take food and drinks off of other residents trays. 6/19/25, R2 was standing in the dining room to the left of a male resident. R2 was observed interacting with newspapers on the table and not engaging with male resident. Male resident reached out and struck R2 on the elbow with a closed fist. Staff removed R2 from the area. 6/30/25, R2 found on the floor of another residents (R3) room. The other resident stated R2 came to her door and she tried to push her out and said R2 pushed back. R2 had a bump on the back of her head. 6/30/25, Due to resident to resident altercation, R2 would remain under constant supervision due to ongoing boundary intrusiveness. 7/3/25, R2 remained one to one with staff. During observation on 7/10/25 at 11:13 a.m., R2 was ambulating independently on the unit. R2 was following a female resident. R2 had newspapers in her hand and was touching the other resident with them. The other resident repeatedly stated, "don't touch me." A staff member was standing with her back to the room, down the hall. Two other staff walked out of the bathroom with a different resident. No staff were in the area to intervene. At 11:20 a.m., the other resident propelled herself out of her room. R2 walked over and placed her hands on the other residents wheelchair. The other resident stated, "no, no, no, don't touch me." R3's Resident Face Sheet indicated she admitted to the facility on 7/17/24. Diagnosis included dementia without behavioral disturbance, agitation, Alzheimer's disease and anxiety. R3's quarterly MDS dated 4/9/25, identified severe cognitive impairment and indicated she displayed	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Vincent	516 WALSH STREET , CROOKSTON, Minnesota, 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
F0600 SS = D	Continued from page 3 physical, verbal and other behaviors 4-6 days of the assessment period and wandering behaviors 1-3 days. The MDS indicated R3 ambulated independently. R3's care plan dated 6/30/25, identified her as a vulnerable adult. The care plan indicated if R3 got violent or physically aggressive staff would implement interventions to minimize risk to self or others. Facility to report and investigate any allegations of suspected abuse. The care plan indicated R3 had been a victim of another residents physical aggression. The care plan directed a mesh screen to her door and directed staff to monitor for behavioral changes indicating fear, withdrawl or anxiety and adjust care accordingly. The care plan identified behavioral symptoms that included hallucinations/delusions. R3's Vulnerable Adult assessment dated 7/9/25, indicated she did not have a history of any type of abuse toward others or self. R3 did not have physical limitation which made her susceptible to abuse, but did have cognitive deficits. The assessment further indicated R3 did not display behaviors that made her susceptible to abuse. R3's Resident Progress Notes identified the following: 6/30/25, Per trained medication aide (TMA), R3 came out of her room asking for assistance. TMA and another caregiver noted R3's right eye was black and blue and swollen and her lip was swollen with a small amount of blood noted. R3 brought the staff to her room where another resident (R2) was lying on the bathroom floor. When asked what happened, R3 stated the other resident was trying to come into her room so she pushed her away and said the other resident back and they both fell on the floor. 7/1/25, R3's family member called regarding incident and inquired about plan to keep R2 out of her room as she felt it startled R3 and she wanted R3 to feel secure. Informed family of stop sign and mesh screen type door and R2 currently being one to one with staff. 7/1/25, R3 had been in her room most of the shift. 7/1/25, R3 had been following another female resident (R2) consistently for about two hours. Staff had been one to one with other resident (R2). After supper R3 went to her room and stayed in the room. 7/6/25, R3 was seated at the breakfast table and noticed female resident (R2) near her room. R3 stated, "that's my room" and immediately got up and walked at a	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Vincent	516 WALSH STREET , CROOKSTON, Minnesota, 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
F0600 SS = D	Continued from page 4 fast pace toward the other resident. Staff was able to intercept. When asked where she was going, R3 said "that women is too close." 7/8/25, R3 had been staying in her room throughout most of shift. Did go out to eat dinner. 7/9/25, R3 stayed in room for most of shift. During observation and interview on 7/9/25 at 4:15 p.m., R3 was seated in a recliner chair in her room. R3 had a bruise above her right eye, and a scab on her lip. When asked about her eye, R3 stated "a fight." R3 said it was the person who for some time would take things from her room. R3 said, "finally, I just said no more of this." R3 remembered the fight and said it happened over there, pointing to the window. R3 said, "I had a bruise, a black eye, and the other." When asked if she was afraid of the other resident R3 said, Yes and said as time goes by it's less and less, then said, "that's not right." R3 said, it just so much and so long, then said, no, for a short time. R3 said she wouldn't sleep. R3 said, "this is how I look at it, she hit me here, and pointed to her eye, and said, it came from the south. R3 said, "it wasn't just you hurt me, I'll hurt you, it was real fighting." R3 said it lessened as time went by but said that doesn't mean it goes away either. During interview on 7/9/25 at 4:30 p.m., nursing assistant (NA)-B stated since the incident R3 had not been out of her room as much. NA-B said normally R3 would walk around the unit. NA-B said she had not seen any issues between R2 and R3 since the incident but said R3 stayed in her room. NA-B said if R3 was out walking, staff tried to keep R2 away. During interview on 7/10/25 at approximately 7:00 a.m., TMA-A stated R3 liked to walk around the unit but said, I know she did not come out of her room much after the incident with R2. TMA-A said R3 would come to an activity then go right back to her room. During interview on 7/10/25, at approximately 7:15 a.m., NA-D said she worked the day after the incident between R2 and R3. NA-D said the only thing she had noticed was one time R3 walked past a table where R2 was seated and R2 said "there she is," in Spanish and seemed very agitated. NA-D said R3 was staring at R2 "very deeply" but had not said anything.	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Vincent	516 WALSH STREET , CROOKSTON, Minnesota, 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
F0600 SS = D	Continued from page 5 During interview on 7/10/25 at 11:36 a.m., NA-C said staff tried to keep an eye on R2 but said sometimes they got busy. NA-C said R3 had been in her room a lot lately and did not come out as much. During interview on 7/10/25 at 1:03 p.m., registered nurse (RN)-B stated after the incident between R2 and R3, staff kept R2 in their visual field and if they saw R2 near other residents they tried to direct her away. RN-B said staff were not assigned to R2 but they worked together to provide supervision to R2. RN-B said they did not have any increase in staffing to supervise following the incident. In regard to the weekend and evening staffing, RN-B said she was not sure what the plan was. RN-B said when she started at the facility they had a designated extra staff person called a safety staff but said they had not had the extra staff for a month or so. RN-B said she had seen some signs of fear/anxiety from R3 but had not asked her if she was afraid of R2. She said she felt R3 had a good recollection of what had happened. During interview on 7/10/25 at 1:29 p.m., the director of nursing said prior to the incident between R2 and R3 they had implemented an extra safety staff member due to a previous resident, The DON said after that resident declined they felt they could pull that position and provide increased supervision when it appeared someone was more agitated. The DON said they provided one to one supervision of R2 the day of the incident and throughout the investigation but no longer had the one to one. The DON said currently they provided more "eyes on supervision." Facility Policy Abuse Prevention Plan dated 7/21/22, indicated Prevention of abuse, neglect, misappropriation of resident property the facility should do the following: Ensure sufficient staffing and appropriate supervisory staff on each shift to meet the needs of the residents. Ensure concerns, incidents and grievances are investigated and steps taken to minimize the likelihood of re-occurrence.	F0600		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F0609	During the survey process it was noted that the facility failed to ensure timely reporting to the state agency of a significant medication error and a resident to resident altercation. The significant medication error involving R1 was submitted to the state agency on 7/1/25 after discussion with the ordering provider verified that she did not intend for the order to start. Education was	08/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Vincent	516 WALSH STREET , CROOKSTON, Minnesota, 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
F0609 SS = D	Continued from page 6 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure timely reporting to the state agency (SA) of a significant medication error for 1 of 3 residents (R1) reviewed for medication errors and failed to ensure timely reporting of an incident of resident to resident abuse for 2 of 3 residents (R2,R3) reviewed for abuse. Findings include: R1's care plan dated 6/27/25, identified the use of high-risk medications for pain. The care plan directed staff to administer medications as ordered and assess for side effects. R1's Physician Order Report dated 6/1/25 through 6/30/25, identified the following medications. -6/6/25, OxyContin 15 milligrams (mg) by mouth every 12 hours. -6/17/25, Oxycodone 5mg every six hours as needed for severe pain. -6/28/25, MS Contin (morphine) 30mg every twelve hours. Discontinued 6/29/25.	F0609	Continued from page 6 provided to the staff on assignment throughout the transcription error to time of transfer to the ER by 7/9/2025. No further events have occurred since 7/10/25. The state agency report for incident between R2 & R3 was submitted on 6/30/25 @ 15:16. The residents were immediately assessed. Immediate action was taken to clearly assign supervision to a designated associate while R2 is awake. Education provided to staff on staff at the time of the incident were educated on the importance of timely reporting suspected abuse incidences. All residents have the ability to be affected by untimely reporting. A review of any reportable incidents since 7/10/25 have been reviewed to ensure timely reporting was completed if indicated. No other residents were affected. The abuse prevention policy was reviewed on 7/30/25and no changes were made. Education has been provided to all related staff on or before 08/06/2025 on the abuse prevention policy and the process to notify supervisor of any events that may be reportable. Education has been provided that included the events that would require notification. Audits will be conducted on documentation 5x per week in reviewing all resident progress notes for any unreported events x 4 weeks. Documentation will then be reviewed for all residents 3x per week x 8 weeks to review for any unreported events. Audits will continue as needed as determined through quality council to ensure compliance. DON/DON designee are responsible for continued compliance. Compliance date 08/06/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Vincent	516 WALSH STREET , CROOKSTON, Minnesota, 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
F0609 SS = D	Continued from page 7 Provider note dated 6/27/25, indicated Oxycontin had been denied due to health care plan. An emergency refill was approved through the weekend. A prescription dated 6/27/25, indicated "do not fill until 6/30/25." MS Contin 30 mg oral tablet extended release by mouth every 12 hours. R1's Medication Administration History dated 6/1/25 through 6/30/25, indicated the following medications were administered: -MS Contin 30mg, 6/28/25 at 12:00 p.m., 6/29/25 at 12:00 a.m. and 6/29/25 at 12:00 p.m. -OxyContin 15mg, 6/2825 at 8:00 a.m., 6/28/25 at 8:00 p.m., 6/29/25 at 8:00 a.m. 8:00 p.m. dose not administered due to condition. -6/30/25, 2:20 a.m., R1 was semi-alert but unresponsive verbally and only able to open eyes partially. R1's pulse was 116 beats per minute; oxygen saturation level was 56 percent on room air. On-call nurse practitioner (NP) was updated and directed staff not to call 911 due to resuscitation status. Family was updated and came to see R1 and requested she be sent to the emergency department (ED). R1's hospital notes dated 6/30/25, indicated R1 admitted for altered mental status and hypoxia (a condition where the body, or a specific part of it, doesn't receive enough oxygen). Apparently have both oxycodone and morphine last afternoon for pain. No Narcan was given and R1 was hypoxic on arrival to ED and barely responded to verbal commands. Her baseline was alert and awake. The current episode started from one to two hours ago and the problem had not changed. Associated symptoms included confusion, somnolence (excessive sleep or drowsiness) and unresponsiveness. R1 responded to three doses of Narcan. Was alert and awake after Narcan but continued to be hypoxic. Started antibiotic to cover aspiration pneumonia secondary to obtundation from opioid overdose. A report to the SA indicated the medication error was reported on 7/1/25, at 6:43 p.m.	F0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Vincent	516 WALSH STREET , CROOKSTON, Minnesota, 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
F0609 SS = D	Continued from page 8 During interview on 7/10/25 at 11:00 a.m., the director of nursing (DON) stated when a significant medication error was identified it should be reported to the SA. The DON said she felt like she had to do a little more digging do determine if the medication error was significant and when she determined it was, she reported the error. The DON said when she learned R1 had been admitted to the hospital it was determined to be a significant error. R2's Resident Face Sheet indicated diagnosis included Alzheimer's disease, insomnia and dementia with behavioral disturbance. R2's Resident Progress Notes dated 6/30/25, indicated R2 was found on the floor of another residents (R3) room. The other resident (R3) stated R2 came to her door, and she tried to push her out and said R2 pushed her back. R2 had a bump on the back of her head. R3's Resident Face Sheet indicated diagnosis included dementia without behavioral disturbance, agitation, Alzheimer's disease and anxiety. R3's Resident Progress Note dated 6/30/25, indicated per trained medication aide (TMA), R3 came out of her room asking for assistance. TMA and another caregiver noted R3's right eye was black and blue and swollen and her lip was swollen with a small amount of blood noted. R3 brought the staff to her room where another resident (R2) was lying on the bathroom floor. When asked what happened, R3 stated the other resident was trying to come into her room so she pushed her away and said the other resident pushed back and they both fell on the floor. An additional Progress Note dated 6/30/25, indicated the incident occurred at 6:40 a.m. A report to the SA indicated the resident-to-resident altercation had been reported 6/30/25 at 3:16 p.m. During interview on 7/10/25 at 1:29 p.m., the DON stated the incident had not been reported to the SA in the required two-hour time frame. The DON said staff had called her at home and she went to the facility and reported as soon as she could. Facility policy Abuse Prevention Plan dated 7/21/22, indicated staff would notify building charge	F0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Vincent	516 WALSH STREET , CROOKSTON, Minnesota, 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
F0609 SS = D	Continued from page 9 immediately any reports of possible abuse, neglect, misappropriation or exploitation. The charge would immediately notify the administrator, DON and social services. If the event that caused suspicion involves abuse or results in serious bodily injury the individual is required to report to the SA immediately, but no later than two hours after forming the suspicion. Abuse was described as: the willful infliction of injury. Neglect described as: Failure of the facility, employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain or emotional distress.	F0609		
F0760 SS = G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure residents remained free from significant medication errors. This resulted in actual harm to R1 who was administered opioid medications prior to the prescribed date resulting in hypoxia, confusion and unresponsiveness and required the use of Narcan (used to reverse the effects of an opioid overdose). Findings include: A report to the state agency dated 7/1/25, indicated R1 had a visit with the palliative care provider on 6/27/25. The provider was informed that the R1's insurance had denied Oxycontin which R1 had been receiving for management of significant pain from fractures that occurred prior to admission to SNF (skilled nursing facility). R1's provider, nurse practitioner (NP)-A, stated that she made numerous calls regarding this patient on Friday afternoon once she received notification of the denied coverage of the Oxycontin from the insurance. After lengthy calls with the insurance provider and pharmacy it was determined the Oxycontin would be extended until they could work through a prior authorization of Morphine for pain management. The provider had to write an order for Morphine to initiate the prior authorization process. However, the order indicated not to fill until on or after 6/30/25. The night nurse received Morphine from	F0760	"Past Noncompliance - no plan of correction required"	08/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Vincent	516 WALSH STREET , CROOKSTON, Minnesota, 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
F0760 SS = G	Continued from page 10 the pharmacy on 6/28/25, around 1:00 a.m. A call was placed to the pharmacy as the facility did not have an order. The pharmacist confirmed the order, indicated the signed order would be sent to the facility. Upon receipt, the night nurse entered the order into the electronic record on 6/28/25 at 1:34a.m. R1 received Morphine while continuing to receive OxyContin. R1's Resident Face Sheet indicated she admitted to the facility on 4/9/25, diagnosis of osteoporosis with fractures of left and right lower leg and left clavicle. R1's admission Minimum Data Set (MDS) dated 4/15/25, identified moderate cognitive impairment, dependent on staff for transfers and had almost constant severe pain. R1's care plan dated 6/27/25, identified the use of high-risk medications for pain. The care plan directed staff to administer medications as ordered and assess for side effects. R1's Physician Order Report dated 6/1/25 through 6/30/25, identified the following medications. -6/6/25, OxyContin 15 milligrams (mg) by mouth every 12 hours. -6/17/25, Oxycodone 5mg every six hours as needed for severe pain. -6/28/25, MS Contin (morphine) 30mg every twelve hours. Discontinued 6/29/25. Provider note dated 6/27/25, indicated Oxycontin had been denied due to health care plan. An emergency refill was approved through the weekend. A prescription dated 6/27/25, indicated "do not fill until 6/30/25." MS Contin 30 mg oral tablet extended release by mouth every 12 hours. R1's Medication Administration History dated 6/1/25 through 6/30/25, indicated the following medications were administered.	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Vincent	516 WALSH STREET , CROOKSTON, Minnesota, 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
F0760 SS = G	Continued from page 11 -MS Contin 30mg, 6/28/25 at 12:00 p.m., 6/29/25 at 12:00 a.m. and 6/29/25 at 12:00 p.m. -OxyContin 15mg, 6/2825 at 8:00 a.m., 6/28/25 at 8:00 p.m., 6/29/25 at 8:00 a.m. 8:00 p.m. dose not administered due to condition. R1's Resident Progress Notes identified the following: -6/28/25, Fax received from pharmacy for MS Contin. Order placed in electronic record. MS Contin 30 mg oral tablet extended release every 12 hours. -6/29/25, 2:52 p.m., R1 was very groggy and not eating or drinking. Writer noted R1 was receiving both OxyContin and MS Contin. Call placed to pharmacy who confirmed R1 should not be receiving both medications at the same time. MS Contin was not supposed to be started unless payment authorization was not received for OxyContin. -6/29/25, 4:07 p.m., R1 resting in bed. She would respond by opening her eyes a little with gentle touch and calling her name. -6/30/25, 2:20 a.m., R1 was semi-alert but unresponsive verbally and only able to open eyes partially. R1's pulse was 116 beats per minute; oxygen saturation level was 56 percent on room air (normal range for oxygen saturation is 95-100). On-call nurse practitioner (NP) was updated and directed staff not to call 911 due to resuscitation status. Family was updated and came to see R1 and requested she be sent to the emergency department (ED). R1's hospital notes dated 6/30/25, indicated R1 admitted for altered mental status and hypoxia (a condition where the body, or a specific part of it, doesn't receive enough oxygen). Apparently had both oxycodone and morphine last afternoon for pain. No Narcan was given and R1 was hypoxic on arrival to ED and barely responded to verbal commands. Her baseline was alert and awake. The current episode started from one to two hours ago and the problem had not changed. Associated symptoms included confusion, somnolence (excessive sleep or drowsiness) and unresponsiveness. R1 responded to three doses of Narcan. Was alert and awake after Narcan but continued to be hypoxic. Started antibiotic to cover aspiration pneumonia secondary to obtundation from opioid overdose.	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Vincent	516 WALSH STREET , CROOKSTON, Minnesota, 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
F0760 SS = G	Continued from page 12 During interview on 7/9/25 at 2:14 p.m., pharmacist (P)-A stated the potential negative effects of too much opioid medication included respiratory distress, increased sedation, Tachycardia (a condition where the heart beats faster than normal, typically over 100 beats per minute), unresponsiveness and hypoxia. During interview on 7/9/25 at 4:57 p.m., registered nurse (RN)-A stated prior to the medication error R1 had been alert and was able to make her needs known. During interview on 7/9/25 at 5:03 p.m., nursing assistant (NA)-A stated R1 had been alert and fairly oriented. NA-A said before the medication error happened, R1 had been coming out of her room more. During interview on 7/10/25 at 9:04 a.m., LPN-A stated early Saturday (6/28/25) morning, a tote arrived from the pharmacy. LPN-A said when she saw the morphine she called the pharmacy and was told they had a prescription. LPN-A said the pharmacy sent a copy of the prescription and she entered the order into the electronic record and had a second nurse verify the order. LPN-A said the prescription had said do not give until 6/30/25, but she had missed it. LPN-A said she had received education following the medication error. During interview on 7/9/25 at 5:09 p.m., the director of nursing (DON) stated when licensed practical nurse (LPN)-A found out the order for the MS Contin had been obtained, she should had read the physical prescription prior to entering the order into and medication record. The DON stated the nurse who verified the order should have compared the prescription with the order. The DON said the facility policy was to have all orders verified by two staff. The DON stated the nurses did not follow the process for entering and verifying orders. The DON stated the nurses involved in the medication error had been immediately educated following the identification of the medication error. In addition, auditing of medical records had been initiated for other residents. During interview on 7/10/25 at 8:46 a.m., nurse practitioner (NP)-A stated R1 had significant pain, and the OxyContin needed insurance authorization. NP-A wrote the order for the MS Contin to start on 6/30/25, if the insurance did not authorize the Oxycontin. NP-A said the potential concerns related to R1 having	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245484	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Vincent	516 WALSH STREET , CROOKSTON, Minnesota, 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
F0760 SS = G	Continued from page 13 received both medications at the same time included respiratory distress and said, "that is what happened." NP-A said the medication error was significant and said she had not written the order while at the facility because she did not want staff to administer the MS Contin to R1. Facility policy related to significant medication errors was requested but not received.	F0760		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 25, 2025

Administrator

Villa St Vincent
516 WALSH STREET
CROOKSTON, MN 56716

Re: State Nursing Home Licensing Orders
Event ID: 43H311

Dear Administrator:

The above facility was surveyed on July 9, 2025 through July 10, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

Please feel free to call me with any questions.

Sincerely,

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Vincent	**516 WALSH STREET , CROOKSTON, Minnesota, 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
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/9/25 through 7/10/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		08/06/2025

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Vincent	**516 WALSH STREET , CROOKSTON, Minnesota, 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
20000	Continued from page 1 The following complaints were reviewed. H54848767C (MN00114350, MN00114544) was reviewed with citation cited at 1545 H54849049C (MN00114300) was reviewed with no orders cited. 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 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. 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.	20000		
21545	Medication Errors CFR(s): MN Rule 4658.1320 A.B.C A nursing home must ensure that: A. Its medication error rate is less than five percent	21545	The facility failed to identify a transcription error that occurred on 6/28/205. The nurse transcribing and the nurse verifying the order failed to follow the facility protocol for medication reconciliation. The error was identified on 6/29/2025 however, the nurse failed to contact the ordering provider for next steps. The nursing staff on shift failed to utilize Narcan	08/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Vincent	**516 WALSH STREET , CROOKSTON, Minnesota, 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
21545	Continued from page 2 as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure residents remained free from significant medication errors. This resulted in actual harm to R1 who was administered opioid medications prior to the prescribed date resulting in hypoxia, confusion and unresponsiveness and required the use of Narcan (used to reverse the effects of an opioid overdose).	21545	Continued from page 2 from the facility standing orders and follow up with ordering provider or on-call provider. The resident was transferred out for further evaluation with hospital admission. Education was provided with the TMA and 3 nurses involved at the time of the interviews. Further education will be provided to the 3 nurses involved specific to their involvement in the error to be completed by 7/11/25 or thereafter on during their next shift. Education has been provided to all staff on process of transcribing and verifying orders. Proper steps to be completed when a medication error is noted, stressing the importance of provider notification. Education was provided to the staff on assignment throughout the transcription error to time of transfer to the ER completed by 7/9/2025. All residents who receive medications have the ability to be affected. All resident receiving new orders from 6/28 to 7/10 have been reviewed for accuracy on start dates. All residents receiving like narcotic medications order from 6/28 to 7/10 have been reviewed for accuracy of start dates with no further findings. The facility medication error policy and medication error report form were reviewed and revised by 7/31/2025. The medication error policy has been reviewed with nursing staff. All licensed nurses will be educated on medication transcription and order start dates. And proper procedure outlined in the facility medication error policy stressing the importance of provider notification. Audits will be completed on new orders on 3 residents per week x 6 weeks and prn thereafter as indicated by quality council. DON/DON designee are responsible for compliance. Compliance date 8/6/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Vincent	**516 WALSH STREET , CROOKSTON, Minnesota, 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
21545	Continued from page 3 Findings include: A report to the state agency dated 7/1/25, indicated R1 had a visit with the palliative care provider on 6/27/25. The provider was informed that the R1's insurance had denied Oxycontin which R1 had been receiving for management of significant pain from fractures that occurred prior to admission to SNF (skilled nursing facility). R1's provider, nurse practitioner (NP)-A, stated that she made numerous calls regarding this patient on Friday afternoon once she received notification of the denied coverage of the Oxycontin from the insurance. After lengthy calls with the insurance provider and pharmacy it was determined the Oxycontin would be extended until they could work through a prior authorization of Morphine for pain management. The provider had to write an order for Morphine to initiate the prior authorization process. However, the order indicated not to fill until on or after 6/30/25. The night nurse received Morphine from the pharmacy on 6/28/25, around 1:00 a.m. A call was placed to the pharmacy as the facility did not have an order. The pharmacist confirmed the order, indicated the signed order would be sent to the facility. Upon receipt, the night nurse entered the order into the electronic record on 6/28/25 at 1:34a.m. R1 received Morphine while continuing to receive OxyContin. R1's Resident Face Sheet indicated she admitted to the facility on 4/9/25, diagnosis of osteoporosis with fractures of left and right lower leg and left clavicle. R1's admission Minimum Data Set (MDS) dated 4/15/25, identified moderate cognitive impairment, dependent on staff for transfers and had almost constant severe pain. R1's care plan dated 6/27/25, identified the use of high-risk medications for pain. The care plan directed staff to administer medications as ordered and assess for side effects. R1's Physician Order Report dated 6/1/25 through 6/30/25, identified the following medications. -6/6/25, OxyContin 15 milligrams (mg) by mouth every 12 hours. -6/17/25, Oxycodone 5mg every six hours as needed for severe pain. -6/28/25, MS Contin (morphine) 30mg every twelve hours. Discontinued 6/29/25.	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Vincent	**516 WALSH STREET , CROOKSTON, Minnesota, 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
21545	Continued from page 4 Provider note dated 6/27/25, indicated Oxycontin had been denied due to health care plan. An emergency refill was approved through the weekend. A prescription dated 6/27/25, indicated "do not fill until 6/30/25." MS Contin 30 mg oral tablet extended release by mouth every 12 hours. R1's Medication Administration History dated 6/1/25 through 6/30/25, indicated the following medications were administered. -MS Contin 30mg, 6/28/25 at 12:00 p.m., 6/29/25 at 12:00 a.m. and 6/29/25 at 12:00 p.m. -OxyContin 15mg, 6/2825 at 8:00 a.m., 6/28/25 at 8:00 p.m., 6/29/25 at 8:00 a.m. 8:00 p.m. dose not administered due to condition. R1's Resident Progress Notes identified the following: -6/28/25, Fax received from pharmacy for MS Contin. Order placed in electronic record. MS Contin 30 mg oral tablet extended release every 12 hours. -6/29/25, 2:52 p.m., R1 was very groggy and not eating or drinking. Writer noted R1 was receiving both OxyContin and MS Contin. Call placed to pharmacy who confirmed R1 should not be receiving both medications at the same time. MS Contin was not supposed to be started unless payment authorization was not received for OxyContin. -6/29/25, 4:07 p.m., R1 resting in bed. She would respond by opening her eyes a little with gentle touch and calling her name. -6/30/25, 2:20 a.m., R1 was semi-alert but unresponsive verbally and only able to open eyes partially. R1's pulse was 116 beats per minute; oxygen saturation level was 56 percent on room air (normal range for oxygen saturation is 95-100). On-call nurse practitioner (NP) was updated and directed staff not to call 911 due to resuscitation status. Family was updated and came to see R1 and requested she be sent to the emergency department (ED). R1's hospital notes dated 6/30/25, indicated R1 admitted for altered mental status and hypoxia (a condition where the body, or a specific part of it, doesn't receive enough oxygen). Apparently had both	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Vincent	**516 WALSH STREET , CROOKSTON, Minnesota, 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
21545	Continued from page 5 oxycodone and morphine last afternoon for pain. No Narcan was given and R1 was hypoxic on arrival to ED and barely responded to verbal commands. Her baseline was alert and awake. The current episode started from one to two hours ago and the problem had not changed. Associated symptoms included confusion, somnolence (excessive sleep or drowsiness) and unresponsiveness. R1 responded to three doses of Narcan. Was alert and awake after Narcan but continued to be hypoxic. Started antibiotic to cover aspiration pneumonia secondary to obtundation from opioid overdose. During interview on 7/9/25 at 2:14 p.m., pharmacist (P)-A stated the potential negative effects of too much opioid medication included respiratory distress, increased sedation, Tachycardia (a condition where the heart beats faster than normal, typically over 100 beats per minute), unresponsiveness and hypoxia. During interview on 7/9/25 at 4:57 p.m., registered nurse (RN)-A stated prior to the medication error R1 had been alert and was able to make her needs known. During interview on 7/9/25 at 5:03 p.m., nursing assistant (NA)-A stated R1 had been alert and fairly oriented. NA-A said before the medication error happened, R1 had been coming out of her room more. During interview on 7/10/25 at 9:04 a.m., LPN-A stated early Saturday (6/28/25) morning, a tote arrived from the pharmacy. LPN-A said when she saw the morphine she called the pharmacy and was told they had a prescription. LPN-A said the pharmacy sent a copy of the prescription and she entered the order into the electronic record and had a second nurse verify the order. LPN-A said the prescription had said do not give until 6/30/25, but she had missed it. LPN-A said she had received education following the medication error. During interview on 7/9/25 at 5:09 p.m., the director of nursing (DON) stated when licensed practical nurse (LPN)-A found out the order for the MS Contin had been obtained, she should had read the physical prescription prior to entering the order into and medication record. The DON stated the nurse who verified the order should have compared the prescription with the order. The DON said the facility policy was to have all orders verified by two staff. The DON stated the nurses did not follow the process for entering and verifying orders. The DON stated the nurses involved in the medication error had been immediately educated following the identification of the medication error. In addition, auditing of medical records had been initiated for other residents.	21545		

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/10/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Vincent	**516 WALSH STREET , CROOKSTON, Minnesota, 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
21545	Continued from page 6 During interview on 7/10/25 at 8:46 a.m., nurse practitioner (NP)-A stated R1 had significant pain, and the OxyContin needed insurance authorization. NP-A wrote the order for the MS Contin to start on 6/30/25, if the insurance did not authorize the Oxycontin. NP-A said the potential concerns related to R1 having received both medications at the same time included respiratory distress and said, "that is what happened." NP-A said the medication error was significant and said she had not written the order while at the facility because she did not want staff to administer the MS Contin to R1. Facility policy related to significant medication errors was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors to include transcription errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medications were correctly transcribed. The quality assurance committee could monitor these measures to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		