



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 24, 2026

Administrator
ST Crispin Living Community
213 Pioneer Road
Red Wing, MN 55066

RE: CCN: 245449

Cycle Start Date: August 10, 2026

Dear Administrator:

On August 10, 2026, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

**Annette Winters, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558**

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 November 10, 2026 (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 February 10, 2027 (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,



Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: File



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August 24, 2026

Administrator
St Crispin Living Community
213 Pioneer Road
Red Wing, MN 55066

Re: Event ID: 31C099-H1

Dear Administrator:

The above facility survey was completed on August 10, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/10/2026	
NAME OF PROVIDER OR SUPPLIER ST CRISPIN LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 213 PIONEER ROAD , RED WING, Minnesota, 55066			
(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 8/10/26 , 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 H54493598C / MN 3132130 with a deficiencies issued at F689 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.			F0000			09/10/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to provide adequate supervision to prevent an accident for 1 of 1 residents reviewed for			F0689	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. How the deficiency will be corrected for the resident found to be affected (R1): R1 was immediately reviewed by the interdisciplinary team for current elopement risk, history of wandering/elopement behaviors, cognition, mobility, behaviors, and current supervision needs. R1's care plan and care card were reviewed and revised to		09/10/2026

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

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F0689 SS = D	Continued from page 1 elopement risk (R1). R1 was known to wander and had a WanderGuard (electronic monitor used to detect when a resident with dementia from exiting the facility) in place. R1 exited the facility through an emergency door, subsequently fell and sustained no injury. Although the facility repaired the door following the incident, the facility failed to implement additional supervision for R1. Findings include: R1’s care plan dated 8/15/25 indicated R1 was at risk for elopement and had a WanderGuard on. He had a history of exiting the stairwell door. His goals with a target date of 9/18/26 indicated he would not leave the facility unattended, his safety would be maintained, and he would demonstrate happiness with daily routines. His approaches were: 8/15/25 Reorient him to person, place and time as needed (PRN). 8/15/25 Identify a pattern of wandering: was it purposeful, aimless, or escapist? 8/15/25 Document all incident of wandering. 8/15/25 Assess for a fall risk. 8/15/25 Apply an alarm for alarm doors i.e., at the elevator and door to the staircase. 8/15/25 Was R1 looking for something? Was wandering a need for more exercise? 9/30/25 WanderGuard in place on right wrist, monitor functioning daily. 8/5/26 For wandering elopement attempts, redirector and offer R1 an independent activity when he returned to his room, such as a word puzzle or call family. R1’s care plan did not indicate any staff supervision of R1. R1’s annual Minimum Data Set (MDS) dated 6/24/26 indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 4 indicated severe cognitive impairment. R1 used a walk and/or a wheelchair for ambulation. R1 required maximal assistance with toileting, lower body dressing and moderate assistance with upper body dressing and			F0689	Continued from page 1 clearly identify the resident's individualized interventions based on the resident's assessed risk and history. How the facility will identify other residents having the potential to be affected: The DON or designee will review all residents identified as being at risk for elopement and/or having a WanderGuard in place. For each identified resident, the medical record will be reviewed to determine the resident's individual elopement risk, including history of wandering or elopement attempts, cognition, behaviors, mobility, and other identified risk factors. The care plan and care card for each applicable resident will be reviewed and updated to clearly identify the required individualized interventions. What measures will be put into place to ensure the deficiency does not recur: The facility's elopement policy (POL_NS301) was reviewed. The facility implemented a process to review residents in IDT to ensure that supervision needs are based on each at-risk resident's individual assessed elopement risk and history. For residents at risk, the facility will ensure: An individualized elopement risk assessment is completed and maintained. The resident's history and current risk factors are considered when determining the level and frequency of supervision. The resident's individualized interventions are clearly identified in the care plan/care card. Staff carry out the individualized interventions care-planned approaches. Staff Education: All licensed nurses and nursing assistants, including agency staff, will receive education regarding the facility’s revised elopement process. Education will include the requirement to		09/10/2026

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F0689 SS = D	Continued from page 2 transferring. R1's pertinent diagnoses were coronary artery disease, post-traumatic stress disorder (PTSD), insomnia, diabetes, and chronic kidney disease. R1's event details dated 8/2/26 at 10:01 p.m. indicated R1 had an unwitnessed fall at 6:00 p.m. R1 was noted missing at around 6:00 p.m. from the unit, last seen before 6:00 p.m. R1's nurse was attempting to give him his medications and R1 was not in his room and nowhere to be found in the neighborhood. An immediate search was initiated; all the residents' rooms and common areas were checked without success. During ongoing rounds, a beeping sound was heard at the back door the nurse attempted to open the door without the code. R1 was found sitting on the floor of the first-floor landing of the back stairwell near the back door beside his wheelchair. R1 was alert, responsive, denied and discomfort. Assessment revealed no visible injuries and no signs of head injuries or distress. R1 was assisted back to his wheelchair and wheeled back to his room on the second floor. R1 was sent to the emergency department. R1's hospital after visit summary dated 8/2/26 indicated, no acute traumatic findings in the chest from the abdomen and pelvis. No acute intracranial findings and no acute traumatic findings in the cervical spine. R1's after event elopement risk observation dated 8/3/26 at 12:00 p.m. indicated R1 exhibited wandering with no rational purpose and he had a recent history (last 6 months) of wandering the facility or elsewhere. R1 had anxiety disorder, dementia, and PTSD. The observation indicated that he was not an elopement risk. The prevention actions taken were: Care plan developed Staff educated on the individual program plan Wander detection system applied Resident photo added to the electronic chart Provider updated The facilities Ad Hoc QAPI Meeting/Four-Point Plan			F0689	Continued from page 2 review and follow each resident's individualized care plan/care card. How the facility will monitor its corrective actions to ensure the deficiency is corrected and will not recur (QA process): The Director of Nursing or designee will complete random audits twice a week for three weeks and then weekly for three weeks for residents at risk of elopement with wanderguards in place per order. The audits will include review of a sample of applicable residents who are at risk for elopement and will verify: The resident has a current elopement risk assessment. The resident's elopement risk and history have been considered when determining individualized interventions. The resident has individualized care plan interventions based on assessed risk/history. Any identified concerns throughout the auditing period will be addressed immediately with additional staff education and/or process changes. The findings of the audits will be presented at QAPI meetings for follow-up and verification of sustained compliance monthly until 100% compliance is met and sustained.		09/10/2026

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F0689 SS = D	Continued from page 3 or Correction Agenda and Summary dated 8/3/26 indicated: Problem statement: The resident, with a functioning WanderGuard in place, exited the secured neighborhood through the back stairwell door. The resident entered the stairwell and was subsequently found on the stair landing, seated on his buttocks with his back toward the stairs and facing the wall. The resident's wheelchair observed upright next to him on the landing. Factors: The doors locking mechanism failed to properly engage, allowing the resident to push the door open while seated in his wheelchair. Door alarm was sounding and audible, but due to the door's location was unable to be heard throughout the neighborhood. Routine environmental safety checks did not identify the mechanical failure before the event occurred. Root causes: The back stairwell door locking mechanism was inoperable, however the WanderGuard did function. This allowed the residents to push the door open and enter the stairwell. Routine inspection and testing processes did not identify the defective door locking mechanism before the event. The mechanical failure was undetected until the resident gained access to the stairwell. Systemic changes: Repair the malfunctioning stairwell door locking mechanism and verify proper operation before removing 24/7 staff from the area. Increase the volume of the door alarms to improve audibility throughout the surrounding area. Conduct a facility-wide inspection and functional testing of all secured exit doors, locking mechanisms, and WanderGuard-controlled access points. Implement additional documented testing of secured exit doors and locking mechanisms - daily two times a week then weekly thereafter with results reported to QAPI for review of continuation. Staff monitoring the area whenever a secured exit door is found to be malfunctioning until repairs are completed. The changes did not include any staff supervision for R1. R1's nursing assistant care assist daily sheet dated 8/10/26 did not indicate any staff supervision of R1.			F0689			09/10/2026

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F0689 SS = D	Continued from page 4 Upon interview on 8/10/26 at 11:31 a.m. nursing assistant (NA)-A stated R1 would either stay in his room an entire shift or roam the hallways an entire shift. Every resident was checked on every two hours as part of the facilities rounding, but there was no specific criteria for staff supervision of R1. Upon interview on 8/10/26 at 11:50 a.m. (NA)-B stated R1 thought he was independent and often wandered trying to leave the facility. Her intervention for R1 was to give him non-alcoholic beer or his mechanical cat when R1 started to wander. There were no guidelines to supervise him on a schedule. Upon interview on 8/10/26 at 1:19 p.m. licensed practical nurse (LPN)-A stated after R1's accident she received training on checking the door and to be sure to not turn any alarm off until a resident was found. When she worked, she would check on R1 every time she passed his room. She denied any formal supervision of R1. Upon interview on 8/10/26 at 2:28 p.m. registered nurse (RN)-B, the nursing supervisor stated R1 had gotten out the back door as the door magnet failed, however his WanderGuard was working. The evening nurse noted he was not in his room and began a search for R1, then they heard the WanderGuard alarm sounding. She stated the staff used the WanderGuard for supervision and he also had interventions of redirection by offering him his mechanical cat and calling his family. R1 had "a lot" of interactions during the day, and staff walk by his room "frequently" to check on him, but there were no specific times to check on him. Upon interview on 8/10/26 at 2:44 p.m. (NA)-C stated on the evening of 8/2/26 he had taken R1 back to his room following dinner around 5:45 p.m. He was offered R1 the bathroom R1 refused and was talking about wanting to leave the facility in his car to see a friend. (NA)-C reassured him he had a room at the facility, and it was too late to go out. R1 seemed o.k. with (NA)-C's idea. A few minutes later (NA)-C heard staff yelling from the stairwell door needing assistance. He ran to the door and found R1 had gotten down the first flight of stairs and was seated on his buttocks with his wheelchair behind him on the first landing. (NA)-C stated the facility fixed the lock mechanism on the door and all staff were educated on how the door worked and to be sure to check the entire stairwell when a resident			F0689			09/10/2026

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F0689 SS = D	Continued from page 5 was missing. When R1 was wandering he was to be redirected and given ice cream or coffee. The staff did not really need to supervise the residents with WanderGuards as the unit was small and the staff knew which residents were at risk for elopements. Upon interview on 8/10/26 at 3:08 p.m. the director of nursing (DON) stated for supervision of residents at risk for elopement the staff were completing checks to ensure the WanderGuards were placed correctly at each shift and were checked weekly that the WanderGuards were working. Staff were aware of residents wandering tendencies per their care plan. A facility policy titled Elopement dated 2018 indicated following an elopement that the resident's care plan must be reviewed and revised to reflect the elopement and a prevention plan developed. The policy did not include any staff supervision of the residents.			F0689			09/10/2026

Minnesota Department of Health

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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 8/10/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure. The following complaints were reviewed during the survey. H54493598C / MN 3132130 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.			20000			09/10/2026

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

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20000	Continued from page 1 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			20000			09/10/2026