MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name: Villa St. Vincent

Facility Address: 516 Walsh Street

Facility City: Crookston

State: Minnesota **ZIP:** 56716 **County:** Polk

Report Number: H5484018 and H5484019

Date of Visit: November 28 and 29, 2016

Time of Visit: 3:00 p.m. to 4:30 p.m. 7:00 a.m. to 4:00 p.m.

Date Concluded: January 4, 2017

Investigator's Name and Title: Jane Aandal, RN

☒ **Nursing Home**

Allegation(s):
It is alleged that a resident was abused by staff/alleged perpetrator when the AP was witnessed to pick up the resident, throw the resident onto the bed, hit, kick, punch and call the resident names. The resident complained of pain and fear. The resident received minor injuries.

☒ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)

☒ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)

☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

☒ State Statutes Chapters 144 and 144A

Conclusion:
Based on a preponderance of evidence physical abuse did occur when the alleged perpetrator (AP) hit the resident's hands two to three times. In addition, the AP hit the resident in the face with a fist.

The resident was diagnosed with dementia with psychotic features and had severe cognitive impairment. The resident required the assistance of one to two staff for transfers and extensive assistance of one staff for dressing and personal hygiene.

On an evening the AP went to administer medications to the resident. After multiple times of offering the medications the resident continued to refuse. After the evening meal the AP observed the resident walking in the hallway without the wheelchair. A staff member witnessed the AP telling the resident multiple times to be seated. The AP told the staff to get a nightgown for the resident. The AP then picked up the resident under the knees and behind the neck and the resident pulled the AP's hair and called the AP a pig. The AP was about two and a half to three feet away from the bed when the AP threw the resident onto the bed. The staff had an unobstructed view of the following events. The AP then put his/her forearm on the resident's throat and forced the resident onto his/her back. The AP then forcefully removed the resident's pants and threw them across the room. The resident told the AP to get off him/her. The AP then moved the resident so s/he was lying in the middle of the bed. The AP was trying to remove the resident's long sleeve shirt and the resident pulled the AP's hair. The AP put his/her knee up on the bed and the resident's shirt

was over the top of his/her head. The AP had his/her hand inside the resident's shirt when it was being removed and then with a fist hit the resident's face. The AP then threw the shirt across the room. The AP then put his/her knee on the resident's upper abdomen and grabbed the resident's wrists to pull them through the nightgown. The AP then ripped off the resident's brief and turned the resident to his/her left side. The staff then applied the new brief. The resident was trying to get to an upright position when the AP laid across the resident's chest and face area. The AP then placed his/her left forearm on the resident's neck. The staff witnessed the AP call the resident a "nasty bitch" and an "old hag." The AP then pulled the blankets up over the resident's face. The AP then kicked the wheelchair and slammed the resident's door when leaving the room.

Staff interview and documentation indicated the resident sustained a light blue/black bruise on the thumb of his/her right hand which measured 2 centimeters (CM) by 2 cm. The resident sustained a dark purple bruise on her left elbow which measured 1 cm by 1 cm.

The AP was interviewed and stated he offered four pills to the resident. The AP stated after 10 times of re-approaching the resident s/he continued to refuse the medications. The AP stated s/he noticed the resident was out of the wheelchair so s/he picked up the resident and carried him/her to the bed. The AP stated due to the resident's weight s/he dropped the resident onto the bed. The AP then asked the staff to bring a nightgown for the resident and the AP stated s/he restrained the resident's arms from hitting him/her. The AP stated the resident was pulling his/her hair when the AP was removing the resident's shirt. The AP stated s/he held the resident's wrists for three to four minutes while removing the shirt and placing the nightgown. The AP stated the resident and him/her were yelling and arguing with each other. The AP stated s/he laid over the resident and leaned on the bed and the resident could still move his/her arms. The AP stated s/he told the resident your husband does not give two shits about you. The AP stated s/he smacked the resident's hands away when the resident tried to hit me. The AP stated he hit the resident's right hand two or three times on the top of the hand or the palm of the hand. The AP stated s/he was more forceful with the resident when removing the pants. The AP stated s/he was charged with fourth degree assault of a vulnerable adult.

The police report indicated the AP was arrested.

The AP was terminated from the facility due to the incident.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☒ Abuse ☐ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Click Here and Type

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☒ Individual(s) and/or ☐ Facility is responsible for the

☐ Abuse ☐ Neglect ☐ Financial Exploitation. This determination was based on the following:
The facility had abuse and neglect policies and procedures and the alleged perpetrator was trained on the policies. The resident had received dementia training. The facility had adequate staffing at the time of the incident.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) – Compliance Met
The facility was found to be in compliance with State Licensing Rules for Nursing Homes (MN Rules Chapter 4658). No state orders were issued.

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No
(The 2567 will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No
(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:
The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 2 - Abuse

"Abuse" means:

(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:

(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;

A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- ☒ Medical Records
- ☒ Care Guide
- ☒ Nurses Notes
- ☒ Assessments
- ☒ Care Plan Records
- ☒ Other, specify:

Other pertinent medical records:

- ☒ Police Report

Additional facility records:

- ☒ Staff Time Sheets, Schedules, etc.
- ☒ Personnel Records/Background Check, etc.

☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: Seven

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A

Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact complainant, attempts were made on:

Date: _____ Time: _____ Date: _____ Time: _____ Date: _____ Time: _____

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation:

◉ Yes ○ No ○ N/A Specify: _____

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Seven

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Eight

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify: _____

Attempts to contact:

Date: _____ Time: _____ Date: _____ Time: _____ Date: _____ Time: _____

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☒ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Nursing Services

☒ Facility Tour

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

The Office of Ombudsman for Long-Term Care

Polk County Medical Examiners

Crookston Police Department

Polk County Attorney

Crookston City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245484	A. BUILDING _____ B. WING _____	C 01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ST VINCENT	516 WALSH STREET CROOKSTON, MN 56716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5484018 and #H5484019. As a result, the following deficiency is issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 223 SS=G	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 8 residents (R1) reviewed for abuse was free from physical and verbal abuse by staff. This failure resulted in harm for (R1) who sustained bruises to both arms. Findings include: R1's medical record was reviewed. R1's face sheet indicated R1 resided on the secure dementia unit, diagnosed with dementia with psychotic features. R1's care plan last revised 7/19/16, indicated R1	F 223		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245484	A. BUILDING _____ B. WING _____	C 01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ST VINCENT	516 WALSH STREET CROOKSTON, MN 56716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223	Continued From page 1	F 223		

required one to two staff for transfers and ambulation with a walker. R1 required extensive assistance of one staff for dressing and personal hygiene.

R1's cognitive assessment dated 10/14/16, indicated R1 had severe cognitive impairment.

R1's event report dated 10/25/16, at 7:43 p.m. documented by licensed practical nurse (LPN)-E, indicated R1 sustained a light blue/black bruise on the right thumb which measured 2 centimeters (cm) by 2 cm. R1 also sustained a dark purple bruise on the left elbow which measured 1 cm by 1 cm.

R1's nursing progress notes dated 10/25/16, at 8:19 p.m. documented by LPN-E indicated R1 had been refusing to take R1's medications. R1 stood up from the wheelchair and ambulated without assistance. When staff approached R1, R1 yelled at staff and hit out. The staff attempted to redirect R1 and R1 became upset with the staff's approach. The staff lifted R1 and placed R1 in bed. Two staff assisted R1 to remove R1's clothing and change R1's incontinent pad. R1 continued to be resistive with cares.

An interview with LPN-E was conducted on 11/29/16, at 1:23 p.m. LPN-E stated on 10/25/16, trained medication aide (TMA)-I stated he had lost his temper when R1 ambulated independently so he picked up R1 and carried R1 to bed. LPN-E stated TMA-I told her R1 was getting physical with him so he held R1's hands and arms.

An interview with NA-F was conducted on 11/29/16, at 3:05 p.m. NA-F stated on 10/25/16,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245484	A. BUILDING _____ B. WING _____	C 01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ST VINCENT	**516 WALSH STREET CROOKSTON, MN 56716**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223	Continued From page 2 at approximately 5:45 p.m. TMA-I attempted to give R1 medications, R1 refused and questioned what the medications were for. TMA-I told R1 she could not leave the table or go to bed unless R1 took the medications. NA-F came out of a resident's room and saw R1 ambulating independently and TMA-I told R1 multiple times to be seated. NA-F stated TMA-I told her to get a nightgown for R1 and then TMA-I picked up R1 under R1's knees and behind R1's neck. NA-F stated R1 pulled TMA-I's hair and called him a "pig." NA-F stated TMA-I was about 2 1/2-3 feet away from the bed when he tossed R1 onto the bed. R1 was seated on the edge of the bed with both feet touching the floor. NA-F stated TMA-I then put his left forearm on R1's neck and forced R1 onto R1's back. NA-F stated TMA-I then forcefully removed R1's pants and threw them across the room, while keeping his left forearm on R1's neck. NA-F stated R1 told TMA-I to get off as R1 tried to get to a seated position. TMA-I tried to remove R1's shirt and R1 pulled TMA-I's hair and called him a "pig." R1's shirt was over the top of R1's head and TMA-I had his right hand inside R1's shirt to remove it and hit R1 in the face with a closed fist. TMA-I then threw R1's shirt across the room. TMA-I put his right knee on R1's upper abdomen and grabbed R1's wrists to pull them through the nightgown. NA-F stated TMA-I then removed R1's incontinent brief and rolled R1 to the left side. NA-F stated she applied the new brief and R1 tried to get to an upright position when TMA-I laid across R1's chest and face area. TMA-I then placed his left forearm on R1's neck and called R1 a "nasty bitch" and an "old hag." NA-F stated TMA-I then pulled the blankets up over R1's face. NA-F stated she immediately went and reported the incident to LPN-H.	F 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245484	A. BUILDING _____ B. WING _____	C 01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ST VINCENT	516 WALSH STREET CROOKSTON, MN 56716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223	Continued From page 3	F 223		

An interview with TMA-I was conducted on 12/1/16, at 12:05 p.m. TMA-I stated on 10/25/16, at about 5:30 p.m. he offered R1 four pills and R1 asked what the pills were for TMA-I stated he told R1 the pill was to help R1 sleep and after 10 times of approaching R1, R1 continued to refuse to take the medications. TMA-I stated he noticed R1 was out of the wheelchair so he picked R1 up and carried R1 to the bed. TMA-I stated due to R1's weight he dropped R1 onto the bed. TMA-I stated he asked NA-F to get a nightgown and TMA-I stated he did restrain R1's arms from hitting him. TMA-I stated R1 was pulling his hair at the time he removed R1's long sleeve shirt. TMA-I stated he and R1 were yelling at each other. TMA-I stated he laid over R1 and leaned on the bed and R1 could still move both arms. TMA-I stated he told R1, R1's husband did not give two shits about R1. TMA-I stated he was arguing with R1 and held R1's wrists for three to four minutes while removing R1's shirt and placing the nightgown. TMA-I stated he smacked R1's hands away when R1 tried to hit TMA-I. TMA-I stated he hit R1's right hand two or three times on the top of the hand or the palm of the hand. TMA-I stated he was more forceful with R1 when he was turning R1 to remove R1's pants.

An interview with NA-F was conducted on 12/1/16, at 2:11 p.m. NA-F stated TMA-I had his hand inside R1's shirt to remove it up and over R1's head when TMA-I's fist hit R1's face.

An interview with NA-G was conducted on 12/1/16, at 2:34 p.m. NA-G stated on 10/25/16, she stayed with R1 in R1's room when NA-F left to notify LPN-H. NA-G stated R1 told her that R1's arm hurt and NA-G noted bruises on R1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245484	A. BUILDING _____ B. WING _____	C 01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ST VINCENT	516 WALSH STREET CROOKSTON, MN 56716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223	Continued From page 4 arms. R1 asked NA-G are you going to hit me again. NA-G stated R1 was very scared. An interview with family member (FM)-J was conducted on 1/3/17, at 10:38 a.m. FM-J stated the day after the incident he visited R1 and R1 stated being scared to stay at the facility. FM-J stated R1 was scared for about a month after the incident. The facility's undated Vulnerable Adult Mistreatment Policy indicated each resident had the right to be free from mistreatment.	F 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00815	A. BUILDING: _____ B. WING _____	C 01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ST VINCENT	516 WALSH STREET CROOKSTON, MN 56716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5484018 and #H5484019. As a result, the following correction order is issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00815	A. BUILDING: _____ B. WING _____	C 01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ST VINCENT	516 WALSH STREET CROOKSTON, MN 56716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. 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.	2 000		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 8 residents (R1) reviewed for abuse was free from physical and	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00815	A. BUILDING: _____ B. WING _____	C 01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ST VINCENT	516 WALSH STREET CROOKSTON, MN 56716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 2 verbal abuse by staff. This failure resulted in harm for (R1) who sustained bruises to both arms. Findings include: R1's medical record was reviewed. R1's face sheet indicated R1 resided on the secure dementia unit, diagnosed with dementia with psychotic features. R1's care plan last revised 7/19/16, indicated R1 required one to two staff for transfers and ambulation with a walker. R1 required extensive assistance of one staff for dressing and personal hygiene. R1's cognitive assessment dated 10/14/16, indicated R1 had severe cognitive impairment. R1's event report dated 10/25/16, at 7:43 p.m. documented by licensed practical nurse (LPN)-E, indicated R1 sustained a light blue/black bruise on the right thumb which measured 2 centimeters (cm) by 2 cm. R1 also sustained a dark purple bruise on the left elbow which measured 1 cm by 1 cm. R1's nursing progress notes dated 10/25/16, at 8:19 p.m. documented by LPN-E indicated R1 had been refusing to takeR1's medications. R1 stood up from the wheelchair and ambulated without assistance. When staff approached R1, R1 yelled at staff and hit out. The staff attempted to redirect R1 and R1 became upset with the staff's approach. The staff lifted R1 and placed R1 in bed. Two staff assisted R1 to remove R1's clothing and change R1's incontinent pad. R1 continued to be resistive with cares.	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00815	A. BUILDING: _____ B. WING _____	C 01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ST VINCENT	516 WALSH STREET CROOKSTON, MN 56716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 3 An interview with LPN-E was conducted on 11/29/16, at 1:23 p.m. LPN-E stated on 10/25/16, trained medication aide (TMA)-I stated he had lost his temper when R1 ambulated independently so he picked up R1 and carried R1 to bed. LPN-E stated TMA-I told her R1 was getting physical with him so he held R1's hands and arms. An interview with NA-F was conducted on 11/29/16, at 3:05 p.m. NA-F stated on 10/25/16, at approximately 5:45 p.m. TMA-I attempted to give R1 medications, R1 refused and questioned what the medications were for. TMA-I told R1 not leave the table or go to bed unless R1 took the medications. NA-F came out of a resident's room and saw R1 ambulating independently and TMA-I told R1 multiple times to be seated. NA-F stated TMA-I told her to get a nightgown for R1 and then TMA-I picked up R1 under R1's knees and behind R1's neck. NA-F stated R1 pulled TMA-I's hair and called him a "pig." NA-F stated TMA-I was about 2 1/2-3 feet away from the bed when he tossed R1 onto the bed. R1 was seated on the edge of the bed with both feet touching the floor. NA-F stated TMA-I then put his left forearm on R1's neck and forced R1 onto R1's back. NA-F stated TMA-I then forcefully removed R1's pants and threw them across the room, while keeping his left forearm on R1's neck. NA-F stated R1 told TMA-I to get off as R1 tried to get to a seated position. TMA-I tried to remove R1's shirt and R1 pulled TMA-I's hair and called him a "pig." R1's shirt was over the top of R1's head and TMA-I had his right hand inside R1's shirt to remove it and hit R1 in the face with a closed fist. TMA-I then threw R1's shirt across the room. TMA-I put his right knee on R1's upper abdomen and grabbed R1's wrists to pull them through the nightgown. NA-F stated TMA-I then removed	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00815	A. BUILDING: _____ B. WING _____	C 01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ST VINCENT	516 WALSH STREET CROOKSTON, MN 56716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 4 R1's incontinent brief and rolled R1 to the left side. NA-F stated she applied the new brief and R1 tried to get to an upright position when TMA-I laid across R1's chest and face area. TMA-I then placed his left forearm on R1's neck and called R1 a "nasty bitch" and an "old hag." NA-F stated TMA-I then pulled the blankets up over R1's face. NA-F stated she immediately went and reported the incident to LPN-H. An interview with TMA-I was conducted on 12/1/16, at 12:05 p.m. TMA-I stated on 10/25/16, at about 5:30 p.m. he offered R1 four pills and R1 asked what the pills were for TMA-I stated he told R1 the pill was to help R1 sleep and after 10 times of approaching R1, R1 continued to refuse to take the medications. TMA-I stated he noticed R1 was out of the wheelchair so he picked R1 up and carried R1 to the bed. TMA-I stated due to R1's weight he dropped R1 onto the bed. TMA-I stated he asked NA-F to get a nightgown and TMA-I stated he did restrain R1's arms from hitting him. TMA-I stated R1 was pulling his hair at the time he removed R1's long sleeve shirt. TMA-I stated he and R1 were yelling at each other. TMA-I stated he laid over R1 and leaned on the bed and R1 could still move both arms. TMA-I stated he told R1, R1's husband did not give two shits about R1. TMA-I stated he was arguing with R1 and held R1's wrists for three to four minutes while removing R1's shirt and placing the nightgown. TMA-I stated he smacked R1's hands away when R1 tried to hit TMA-I. TMA-I stated he hit R1's right hand two or three times on the top of the hand or the palm of the hand. TMA-I stated he was more forceful with R1 when he was turning R1 to remove R1's pants. An interview with NA-F was conducted on 12/1/16, at 2:11 p.m. NA-F stated TMA-I had his	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00815	A. BUILDING: _____ B. WING _____	C 01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ST VINCENT	516 WALSH STREET CROOKSTON, MN 56716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21850	Continued From page 5 hand inside R1's shirt to remove it up and over R1's head when TMA-I's fist hit R1's face. An interview with NA-G was conducted on 12/1/16, at 2:34 p.m. NA-G stated on 10/25/16, she stayed with R1 in R1's room when NA-F left to notify LPN-H. NA-G stated R1 told her that R1's arm hurt and NA-G noted bruises on R1's arms. R1 asked NA-G are you going to hit me again. NA-G stated R1 was very scared. An interview with family member (FM)-J was conducted on 1/3/17, at 10:38 a.m. FM-J stated the day after the incident he visited R1 and R1 stated being scared to stay at the facility. FM-J stated R1 was scared for about a month after the incident. The facility's undated Vulnerable Adult Mistreatment Policy indicated each resident had the right to be free from mistreatment. SUGGESTED METHOD OF CORRECTION: The administrator could provide all nursing staff with re-education on the vulnerable adult policy. The quality assessment and assurance committee could implement monitoring on all shifts of work to ensure all residents are receiving the appropriate care and treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21850		

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 29, 2017

Ms. Judith Hulst, Administrator
Villa St Vincent
516 Walsh Street
Crookston, Minnesota 56716

RE: Project Number S5484026, H5484018 and H5484019

Dear Ms. Hulst:

On January 13, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective December 18, 2016. (42 CFR 488.422)

In addition, on January 13, 2017, as authorized by the Centers for Medicare and Medicaid Services (CMS), the Department informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 15, 2017. (42 CFR 488.417 (b))

Futhermore, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 15, 2017.

This was based on the deficiencies cited by this Department for a standard survey completed on December 15, 2016 and an abbreviated standard survey completed on January 11, 2017. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On January 26, 2017, the Minnesota Department of Health, Licensing and Certification Program completed a Post Certification Revisit (PCR) by review of your plan of correction. On February 1, 2017 the Minnesota Department of Health Office of Health Facility Complaints completed a PCR and on March 1, 2017, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 15, 2016 and an abbreviated standard survey completed on January 11, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 28, 2017. Based on our visit, we determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 15, 2016 and abbreviated standard survey completed on January 11, 2017, effective February 28, 2017.

As a result of the revisit findings, we are discontinuing the Category 1 remedy of state monitoring as of February 28, 2017.

In addition, the Department recommended the following action to the Centers for Medicare and Medicaid Services (CMS) Region V Office related to the remedies outlined in our letter of January 13, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 15, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective March 15, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective March 15, 2017, is to be rescinded.

In our letter of January 13, 2017, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 15, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on February 28, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 29, 2017

Ms. Judith Hulst, Administrator
Villa St Vincent
516 Walsh Street
Crookston, Minnesota 56716

Re: Enclosed Reinspection Results - Complaint Number H5484018 and H5484019

Dear Ms. Hulst:

On February 1, 2017 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on January 11, 2017. At this time these correction orders were found corrected.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the president of your facility's governing body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697