STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Crispin Living Community	213 Pioneer Road Red Wing, MN 55066

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 51379 Based on observation, interview and record review, the facility failed to properly bag and contain contaminated linen placed under a basket of clean resident laundry and maintain a clean laundry room used for resident personals. This had the potential to affect all 15 residents on the 300 unit. Findings include: During a tour of the 300-unit laundry room on 2/26/25 at 7:32 a.m., registered nurse (RN)-A stated dirty linens are bagged and put in the soiled utility room to be picked up by housekeeping staff on each unit and taken to the main utility room to be picked up by a contracted linen company. The process for resident clothing is completed by nursing assistant (NA)'s on resident's bath day. NA's bring resident's personal laundry to the unit laundry room, washes and dries the items and places them back in a basket on wheels. The basket on wheels is taken to the resident room to be folded or hung. The NA's used a dry erase board to communicate to other staff what residents' items are in each machine. The 300-unit laundry room had an unbagged yellow-stained contaminated bed sheet on the floor; with residents' clean personal laundry sitting in the basket on wheels above the contaminated linen. The floor of laundry room was dirty with used lint scraps under the sink and under basket on wheels. There was a used paper towel under the sink. Lint pieces were stuck to the white board and along floorboards. The detergent compartment on the washer was dirty with lint scraps and old soap. RN stated they used to use the pods for detergent but had recently switched to Ecolab products and the detergent was now completed with this system. The 300-laundry room smelled of wetness and mildew . During an interview on 2/26/25 at 7:22 a.m., maintenance (M)-A stated resident personal laundry is completed in the laundry rooms on each unit. M-A stated he does not collect dirty linens from unit laundry rooms. During an observation and interview on 2/26/25 at 8:30 a.m., NA-A stated it was the responsibility of the NA's to keep the unit laundry room tidy and clean. The wetness and mildew smell remained, the garbage remained, and the soiled bedsheet remained on the floor. During an interview on 2/26/25 at 9:05 a.m., housekeeper (H)-A stated the NA's do the laundry and keep the laundry room clean. She does the housekeeping for the resident rooms and common areas. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. Building B. Wing	02/27/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 2/26/25 at 10:24 a.m., director of nursing (DON) and regional registered nurse (RRN) viewed the 300-unit laundry room. RRN confirmed there is a yellow-stained unbagged dirty bed sheet sitting beneath resident clean laundry in the basket on wheels. The DON and RRN confirmed the piece of unbagged contaminated linen should be bagged and in the dirty linen utility room . The DON stated the NA's are responsible for keeping the laundry rooms clean. The RRN confirmed the laundry room smelled wet like mildew and the DON had donned gloves to put the contaminated sheet in a plastic bag, placed in the soiled utility room returned to tidy up. During an interview on 2/27/25 at 9:43 a.m., the infection preventionist (IP) stated facility soiled linens (bed clothes, towels, wash cloths, incontinence pads) are bagged at point of care and taken to the soiled utility room at the end of each hall. Soiled linens are outsourced for washing. Resident's personal laundry is stored in baskets in the resident's room and then taken to the laundry room on each unit for washing. Resident's laundry is washed one resident at a time. The IP stated there are times soiled facility linens get mixed up with the residents' personal clothing. IP confirmed all dirty linens/clothing to be kept separate from clean linen. A policy dated 5/15/24 stated dirty linens should be bagged at the point of use and kept separate from clean laundry and linens.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 51578 Based on observation, interview, and record review, the facility failed to maintain kitchen equipment used to keep food warm prior to serving. Findings include: During an observation and interview on 2/24/25 at 1:47 p.m., culinary director (CD) was preparing the lunch meal and placing food into a hotbox (an insulated container for food storage). CD stated the food was kept in the hotbox until ready to go to each floor's kitchenette. The hotbox had a top and bottom compartment. There was a container of egg rolls in the top compartment of the hotbox to be served to the residents for dinner. The internal temperature of the bottom compartment read 156 degrees, the top compartment did not have an internal thermometer and an external display which read E00. CD was unable to provide clarification on what the E00 meant. CD was uncertain of when the last time the hotbox was serviced. During an observation of second floor dining room on 2/24/25 at 5:09 p.m., dietary aid (DA-A) took temperatures of egg rolls with an internal reading of 120 degrees. Surveyor intervened and asked what the temperatures should be of foods being served to the residents. CD removed the egg rolls to rewarm prior to serving. During an interview on 2/25/25 at 9:01 a.m., CD reviewed the use of the hotbox and stated it is only used for 20-30 minutes prior delivering foods to kitchenettes. CD was unaware the machine was not working and could not provide an explanation off what the display E00 reading meant. CD was unaware of any maintenance on the hotbox or if serviced on a regular basis. CD stated the expectation would be to have a working thermometer for both the top and bottom compartments prior to usage. The staff were to be monitoring the temperatures of the items placed in the hotbox and the temperatures should have been logged. CD indicated improper food temperatures increased the risk of a food borne illness. CD explained when equipment is not working properly, staff were to notify the supervisor and/or maintenance to get the machine fixed. During an interview on 2/25/25 at 3:21 p.m., environmental services manager (ESM) stated he could not find a service slip or maintenance request since January. ESM mentioned, at one time there had been two of the hotboxes in the kitchen and used one to fix the current one but could not verify the timeframe on when this occurred. During an interview on 02/27/25 at 11:40 a.m., administrator stated being unaware of the equipment not working in the kitchen. Administrator explained the expectation would be if staff identify something wrong or broken, then the piece of equipment should be taken out of service until the department supervisor or maintenance could review and repair. Administrator verified there was a potential for foodborne illness if food was not held at correct temperatures. Maintenance logs and equipment information was asked for and not provided.