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	03/19/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to complete medication side effect monitoring for 1 of 5 residents (R49) reviewed for unnecessary medications who received antipsychotics. Findings include: R49's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated R49 had moderate cognitive impairment with no behaviors. R49 required substantial/maximal assistance with personal hygiene, showering/bathing, and upper body dressing. R49 was dependent on facility staff for lower body dressing, position transfers, and toileting. R49's care plan dated 3/13/2025, titled Psychotropic Drug Use-I have a DX: Depression et receive psychotropic medication as ordered indicated: R49 will not experience any adverse reactions through the review date. R49's care plan lacked guidelines for orthostatic blood pressure monitoring; a potential side effect of psychotropic medications. R49's Medication Administration Record (MAR) indicated the following:-Give Risperdal (an antipsychotic medication used to treat psychiatric symptoms) 0.5 mg once in the evening. R49's orders lacked orthostatic blood pressure monitoring. R49's vital signs record lacked orthostatic blood pressure readings. R49's progress notes lacked documentation orthostatic blood pressures were attempted or any refusals. During an interview on 3/18/26 at 12:33 p.m., licensed practical nurse (LPN)-A stated not many residents have orders for orthostatic blood pressure monitoring. LPN-A stated orthostatic blood pressure monitoring would be a provider order or a task populated from the care plan. LPN-A stated R49 did not have a provider order or care planned task for orthostatic blood pressure monitoring. LPN-A was unsure why someone on antipsychotic medication would need orthostatic blood pressure monitoring. During an interview on 3/19/26 at 9:32 a.m., Regional Director of Clinical Services (RCS) and Registered Nurse (RN)-A stated when a resident is started on an antipsychotic, such as Risperdal, the facility has a protocol they implement to ensure side effect and symptom monitoring is completed. RCS stated side effect monitoring included orthostatic blood pressure monitoring. RCS and RN-A confirmed orthostatic blood pressure monitoring orders and care planned tasks were not completed for R49. RCS stated orthostatic blood pressure monitoring is important for residents taking antipsychotic medications because low blood pressure can be a side effect of the medications. A facility policy for psychotropic medication monitoring was asked for and was not received.

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

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide for activities of daily living (ADL) for 2 of 2 residents (R1, R3) who were dependent on staff for timely incontinence care and eating assistance (R1) and assistance for personal hygiene (R3).Findings include: R1: R1's significant change Minimum Data Set (MDS) dated [DATE], indicated R1 had severe cognitive impairment with no behaviors. R1 required substantial assist with eating, was dependent on staff for all other ADLs, received a mechanically altered diet, and received hospice care. R1 also had a stage 3 pressure injury. R1's diagnoses list, undated, included dementia, kidney disease, anemia, and left heel pressure injury. R1's provider orders included hospice care due to late onset Alzheimer's (a disorder causing progressive decrease in cognition), provide oversight/intake assistance at mealtimes and as needed, and treatment orders to a pressure injury to left heel. R1's care plan last reviewed 2/10/26, indicated incontinent of bladder and bowel and check and change every 2-3 hours and as needed', reposition every 2-3 hours and provide assistance with eating, per nursing determination and left heel pressure injury. R1's progress notes dated 3/13/26, indicated Resident fed by staff food and fluids this shift. Ate 100% of meal. Resident could not feed self, due to continued weakness. During semi-continuous observation on 3/18/26 the following was observed: -9:29 a.m., R1 was seated in the wheelchair in the common area -10:15 a.m., an unidentified staff member took R1 to church service. -11:39 a.m., an activities aide brought R1 back from church to the dining room for lunch. -12:04 p.m., a staff member [NAME] R1 her lunch of a peanut butter and jelly sandwich, mashed potatoes, and cooked carrots. The staff member handed half the sandwich to R1. R1 ate the half sandwich however made no attempt to eat the rest of the food on her plate. No staff present to assist or encourage R1 to eat. -12:15 p.m., nursing assistant (NA)-B handed R1 the other half sandwich and offered her a drink. R1 ate the half sandwich while NA-B assisted tablemates. When the tablemates declined assistance, NA-B walked away. R1 finished the half sandwich and made no further attempt to eat. -12:21 pm., a staff member was observed sitting at a table on the other side of the dining room assisting another resident. A nurse arrived a R1's table and assisted a tablemate to eat. The nurse spoke to R1 however did not offer to assist with feeding. -12:33 p.m., R1 remained at the table. No attempts made to eat or drink. No staff present to assist. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-12:47 p.m., R1 remained at the table with the remainder of her food untouched. Incontinence care/eating assistance During an interview on 3/18/26 at 12:49 p.m., nursing assistant (NA)-A stated R1 is dependent on staff for all activities of daily living and is provided incontinence care every 2-3 hours. NA-A stated R1 was provided incontinence care at around 10:00 a.m., however then stated she was not aware R1 was taken to church. NA-A then stated, I have to lay her down now and change her. NA-A stated R1 will hold and eat sandwiches however requires staff assistance with other foods. R1 doesn't each much but will if someone helps her. NA-A confirmed she did not assist R1 with eating at lunch. During observation at 12:55 p.m., (3 hours and 26 minutes after the first observation) R1 was taken back to her room and transferred into bed. R1 had been incontinent of urine and the back of R1's thighs had reddened indentations resembling the shape of the waffle pressure relieving cushion on her wheelchair. During interview on 3/18/26 at 3:19 a.m., licensed practical nurse (LPN)-A stated R1 has advanced dementia and requires assistance for all ADLs. LPN-A stated R1 sits at the assisted table and will sometimes feed herself. One nursing assistant is assigned to monitor the dining room however they will occasionally get pulled out [of the dining room]. Eating assistance During an interview on 3/19/26 at 9:08 a.m., registered nurse (RN)-B confirmed R1 is under hospice care. RN-B stated R1 required full assistance with eating. R1 will stare at food in front of her and make no attempt to feed self. RN-B stated, even if I hand her finger food, she will put it down. RN-B stated she tries to schedule visits during mealtimes to assist R1 with eating. There are days R1 does not eat much however will normally eat 100% when RN-B assists her. During an interview on 3/19/26 at 9:25 a.m., the registered dietician (RD) confirmed R1 is under hospice care and nutrition is provided for comfort. The RD confirmed R1 has a pressure injury and continues to be followed while under hospice care. The RD stated it is common sense nutrients are needed for wounds to heal and not get worse. The nursing department determines the type of assistance a resident requires for eating. Eating assistance/Incontinence care During an interview on 3/19/26 at 10:37 a.m., the Regional Director of Clinical Services stated it is expected all dependent residents are repositioned and provided incontinence care every 2-3 hours. It is also expected staff assist dependent residents with eating to promote wound healing. A policy titled Activities of Daily Living dated 2021 indicated residents unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming, personal hygiene, elimination, communication and mobility. Care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care), elimination (toileting) and dining (meals and snacks). R3: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's quarterly Minimum Data Set (MDS) dated [DATE] indicated R3 was cognitively intact with some refusals of care from specific staff. R3 is dependent on staff for personal hygiene, toileting hygiene, and lower body dressing. R3 requires substantial/maximal assistance for oral hygiene, shower/bathing, and upper body dressing. R3's diagnosis includes Alzheimer's disease (progressive, incurable neurological disorder that causes brain cells to die), peripheral neuropathy (damage to the peripheral nerves, often causing numbness, tingling, weakness, in hands and feet), major depressive disorder, and generalized weakness. R3's provider orders included bath day Thursday PM: obtain weight, vitals, and observe for new skin issues. Include grooming performed, shaving, nail care etc. Document refusals and approaches used. R3's treatment administration record (TAR) indicated R3 received a bath on 3/5/26 at 7:34 p.m., Bath completed, redness under right breast noted, Linens changed. VSS done and recorded. Resident had all snack between meals 100%, pleasant and cooperative with cares. Additionally, R3 received a bath on 3/12/26 at 11:40 p.m., Resident received a scheduled tub bath, no c/o pain or discomfort, no skin issues noted. Vital signs are intact. R3's care plan dated 1/26/26, titled I have a self-deficit with the following activities of daily living, bathing, grooming, oral cares, ambulation, transferring, mobility, vision, bowel and bladder indicated: R3 will participate as able. R3's interventions for self-deficit included asking for assistance, require assistance of 2 for toileting needs, and assist of 1 with dressing/undressing, grooming, and hygiene. During an observation on 3/17/26 at 5:44 p.m., R3 had multiple long hairs on her upper lip and multiple long hairs on her chin. During an observation and interview on 3/18/26 at 10:06 a.m., R3 stated she does not like the hairs on her face (upper lip and chin), stated she had told staff that she wanted them removed but no one has helped her. R3 stated she wonders why they don't do it on bath days, that would be the easiest. During an interview on 3/18/26 at 12:29 p.m., nursing assistant (NA)-C confirmed R3 had several long hairs on both her upper lip and chin. NA-C stated facial hair removal or shaving occurred on bath days. NA-C stated R3 is very particular about who provides her care; R3 will complete tasks without issue if she trusts you. NA-C confirmed R3 had not refused bathing/grooming assistance in the last month. During an interview on 3/18/26 at 12:33 p.m., licensed practical nurse (LPN)-A stated R3 will refuse cares if she doesn't know or trust you. LPN-A stated when a nursing assistant tells her the resident is refusing something, LPN-A will make sure to ask a trusted nursing assistant to complete the task. LPN-A confirms hair removal and grooming typically occurs on bath days. LPN-A stated she did see the long hairs on R3's upper lip and chin while administering medications this morning. LPN-A stated she was aware the facial hair bothered R3; she would go back and assist R3 with hair removal in a little bit. During an interview on 3/18/26 at 12:41 p.m., regional director of services (RDS) stated facial hair removing and grooming typically occurs on bath days. RDS stated the expectation is facial hair on women is removed as it grows, as it is care planned, and generally on bath days. RDS confirmed R3 has an order to shave on bath days and there were no documented refusals of grooming/hygiene care. RDS stated it is important the resident's grooming needs are met, especially if the lack of grooming was upsetting to the resident.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review, the facility failed to ensure proper food storage for 2 of 2 resident refrigerators that contained undated and unlabled food.Findings include:During observation on 3/18/26 at 11:46 a.m., the 2nd floor refrigerator located near the dining room contained an undated and unlabeled yogurt container 3/4 full with a pasta salad. A 2nd undated and unlabeled yogurt container was 3/4 full with soup. A sign on the refrigerator stated stored items should contain the date placed in the fridge, use-by date (3 days from the original date), resident name, and room number. Any items with missing information will be discarded immediately. Not to be stored in a re-used single use container i.e. cottage cheese and salad dressing containers cannot be reused for food storage. Following the 3rd day, items and containers will be disposed of. [Facility name] will not be responsible for returning containers, they will be discarded.During an interview on 3/18/26 at 11:53 a.m., dietary aide (DA)-A stated dietary staff check the temperatures of the resident refrigerator however housekeeping is responsible for cleaning the inside and verifying food is labeled and dated. During an interview on 3/18/26 at 12:11 p.m., housekeeper (H)-A stated they are responsible for cleaning the dining rooms and common areas. They do not clean resident use refrigerators. During an observation on 3/18/26 at 3:25 p.m., the 1st floor refrigerator located near the dining room contained a clear plastic container of fresh pineapple. The container had a room number however was not dated. During an interview on 3/18/26 at 3:37 p.m., the dietary manager (DM) stated dietary staff are responsible for checking the temperature of the refrigerators however housekeeping cleans and checks dates of the food twice a week. The DM also stated staff have a habit of putting their personal food items in the refrigerator. During an interview on 3/18/26 at 3:55 p.m., the environmental services director stated dietary staff are responsible for checking the temperature of the refrigerators. One housekeeper is responsible for cleaning resident rooms on each floor. A float housekeeper is responsible for cleaning and checking the dates and labels of food items in the resident refrigerators weekly. The environmental services director stated staff should not be putting personal foods in the resident refrigerator and confirmed the items in question were not dated or labelled appropriately. During an interview on 3/19/26 at 7:20 a.m., H-B stated the resident refrigerator is checked weekly by the common area housekeeper. During an interview on 3/19/26 at 10:37 a.m., the Regional Director of Clinical Services (RCS) stated housekeeping staff are responsible for cleaning the resident refrigerators and ensuring all food items are dated and labeled appropriately twice a week.A policy titled Safe Food Storage and Handling for Food Brought in by Residents, Families, and visitors dated 2019 indicated All food stored in the refrigerator/freezer units should be in covered, seamless containers or otherwise suitably protected with date the product was given to the community for storage, use by date (max of 3 days) name and room number of resident. Storage of large quantities of food in oversized containers should be avoided. The policy also indicated All residents should be verbally informed that a product has been placed for them in storage and that all products not used within 3 days will be discarded. Single-use containers such as cottage cheese and salad dressing containers cannot be re-used for direct food storage.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain a medical record that was accurately documented for 1 of 1 resident (R49), who was reviewed for weight monitoring.Findings include: R49's quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated R49 had moderate cognitive impairment with no behaviors. R49 required substantial/maximal assistance with personal hygiene, showering/bathing, and upper body dressing. R49 was dependent on facility staff for lower body dressing, position transfers, and toileting. R49's diagnosis included ischemic heart disease (a condition where reduced blood flow to the heart muscle, usually caused by plaque buildup, causes oxygen deprivation), generalized muscle weakness, dementia (a decline in mental ability), and dysphagia (difficulty swallowing, often caused by dementia, can lead to malnutrition and dehydration). R49's provider orders included an order to obtain daily weights for registered dietician review on 4/8/25. R49's dietary supplements were discontinued on 1/26/26. During record review, R49's daily weights fluctuated with inconsistent readings noted at several intervals. Weight measurements included:-3/16/25: 132-4/9/25: 128-4/22/25: 129-4/23/25: 128-8/4/25: 123-8/13/25: 134-8/18/25: 118-8/19/25: 130-11/19/25: 142-12/14/25: 100-12/19/25: 213-12/24/25: 141-3/12/26: 145 R49's dietary supplements were adjusted on the following dates:-3/21/25: start Glucerna (nutritional supplement drink) 8 oz in the morning w/breakfast-3/27/25: increase Glucerna 8 oz twice per day-4/15/25: change to Ensure (nutritional supplement drink) 8 oz twice per day-12/15/25: change to Ensure 8 oz daily-1/26/26: discontinue supplement During an interview on 3/19/26 at 12:33 p.m., Regional Director of Services (RDS) reviewed R49's weight documentation; confirmed weight documentation is inconsistent and likely incorrect. RDS stated inaccurate weight documentation should have been deleted. During an interview on 3/19/26 at 2:23 p.m., registered dietician (RD) stated R49's weight has fluctuated for some time. RD stated she had previously asked facility staff to assist her with getting and documenting accurate weights. RD stated she asked for a weight verification order on 3/11/26; obtain resident weight two times x 1 week on 3/12/26 and on 3/15/26. A weight was documented on 3/12/26, but there was no documentation of weight in the treatment administration record (TAR) nor a progress note indicating why the order was not completed on 3/15/26. RD stated it has been difficult to make dietary supplement recommendations due to the inaccuracy of R49's documented weights. During interview on 3/19/26 at 3:36 p.m., RDS confirmed again the inaccurate weights for R49 should have been deleted. RDS confirmed how difficult it could have been to manage R49's dietary supplements when the documented weights were inaccurate. RDS stated it is important to get accurate weights and document appropriately to ensure residents get the correct treatment based on accurate information. A facility policy for accurate charting was requested and not received.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and document review, the facility failed to ensure proper antibiotic time out follow-up and ensure that appropriate antibiotics were utilized to prevent potential antibiotic resistance for 1 of 1 resident (R55) reviewed for multiple urinary tract infections.Findings include:R55s quarterly Minimum Data Set (MDS) assessment, dated 02/17/2026 identified R55 no cognition impairment, and substantial assistance with activities of daily living. R55 had diagnoses including hypertensive heart failure, diabetes mellitus with diabetic chronic kidney disease, and benign prostatic hyperplasia (prostate enlargement) with lower urinary tract symptoms.R55's January 2026 medication administration record (MAR) identified R55 was administered Macrobid (nitrofurantoin) 100 mg capsule, by mouth 2 times a day from 1/13/26 to 1/18/206 for urinary tract infection.Review of R55's medical record identified a urine analysis was completed on 01/10/26, result received on 1/11/26 indicated positive urine analysis. Urine culture results received on 1/15/26 indicated organisms identified as Proteus mirabilis with sensitivity to the following antibiotics: Ampicillin, Piperacillin /tazobactam, Cefazolin, Ceftazidime, Ceftriaxone, Cefepime, Aztreonam, Ertapenem, Meropenem, Gentamicin, Tobramycin, Levofloxacin, Trimethoprim/Sulfamethoxazole.R55 was treated with an antibiotic not sensitive to the organism identified based on the urine culture result.R55's 72-Hours Antibiotic time out (a formal structured reassessment of a patient antimicrobial therapy conducted 48-72 hours after initial administration of antibiotic) review completed on 1/16/26 indicated McGeer ?s Criteria (standardized surveillance definition used to identify and track infections such as urinary tract infection) to treat indicated, met.R55's record review indicated McGeer ?s Criteria and culture was not met.R55 's March 2026 MAR identified R55 was administered ciprofloxacin 250 mg by mouth 2 times a day from 03/6/26 to 03/13/26 for urinary tract infection.Review of R55's medical record identified no urine analysis was ordered or completed before or after the start of the antibiotic.R55's 72 -Hours Antibiotic time out review completed on 3/10/26 indicated, McGeer ?s Criteria to treat was not met, and culture or imaging test did not confirm infection.During an Interview on 3/19/2026 11:19 a.m., the infection preventionist (IP) acknowledged 72 -Hours Antibiotic time out reviews completed on 1/16/26 and 3/10/26 lacked accuracy and follow up on issues identified.Facility policy titled: Antibiotic Stewardship Program and Community Protocols reviewed on 3/2025 indicated, based on review of the clinical situation, pertinent lab and diagnostic tests, the provider and nursing associate will identify whether antibiotics are warranted or whether those that have already been started should continue or change.