

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/09/2024
NAME OF PROVIDER OR SUPPLIER Villa St Vincent		STREET ADDRESS, CITY, STATE, ZIP CODE 516 Walsh Street Crookston, MN 56716	

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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>35569</p> <p>Based on observation, interview and document review the facility failed to implement interventions to protect 2 of 2 residents (R1, R2) from resident to resident abuse when R2, who had a history of pushing other residents, initiated an altercation with R1 which resulted in R1's transport to the Emergency Department (ED) for a scalp laceration repaired with sutures. This resulted in harm for R1.</p> <p>Findings include:</p> <p>R2's Resident Face Sheet indicated he admitted to the facility 11/3/22. R2's diagnosis included Alzheimer's disease, depression, dementia, obsessive compulsive disorder (OCD), unspecified head injury and disorientation.</p> <p>R2's care plan dated 8/2/24, identified a risk for impaired psychosocial well-being due to cognitive impairment and indicated he could become aggressive toward others. The care plan further identified a risk for harming others and indicated he had been aggressive (pushed) another resident. The care plan identified the use of a stop sign on R2's door to deter others from entering and directed staff to close door when appropriate and re-direct R2 or others away if showing agitation.</p> <p>R2's Observation Detail List, Behavior Conditions dated 8/2/24, identified Alzheimer's Disease, subarachnoid hemorrhage, OCD and depression. The observation indicated physical behaviors toward others occurred 1-3 of the past seven days and indicated the behaviors put others at significant risk for injury.</p> <p>R2's Resident Progress Notes identified the following:</p> <p>-7/25/24, R2 stated to nursing assistant (NA) he had had pushed another resident who had come into his room.</p> <p>-8/1/24, R2 was seen pushing another resident that morning. When approached R2 stated, she was taking his walker. Resident informed it was not appropriate to push residents.</p> <p>-8/4/24, 1:09 p.m. R2 noted to be entering other residents rooms. Denied when approached until staff mentioned he had been seen entering or leaving another's room.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During observation on 8/8/24 at 12:22 p.m., R2 was observed leaving the dining room. He entered his room, re-applied a Velcro stop sign to his door, and shut the door.</p> <p>R1's Resident Face Sheet indicated she admitted to the facility 10/19/23. R1's diagnosis included Alzheimer's Disease, head laceration, dementia, anxiety and depression.</p> <p>R1's care plan dated 7/29/24, identified inappropriate behaviors exhibited by wandering into other residents rooms, taking things and becoming defensive/combative with directions. The care plan indicated R1 was unaware of personal boundaries and property and did not appear to comprehend direction. The care plan directed if R1 was wandering in potentially dangerous area or near residents known for agitation/aggression to escort away and provide diversional activity. The care plan further indicated she had been a victim of another resident's physical aggression.</p> <p>R1's Resident Progress Notes indicated the following:</p> <p>-8/4/24, 1:30 p.m. R1 was attempting to push residents around in their wheelchairs multiple times. Redirection attempted without success.</p> <p>-8/4/24, 4:37 p.m. R1 was found lying on her back on the floor in the common area with a pool of blood under her head. R1 complained of pain to her coccyx. Sent to ED.</p> <p>R1's ED visit note dated 8/4/24, indicated she was brought in by ambulance after an unwitnessed fall with scalp laceration. laceration repaired with sutures.</p> <p>A report to the state agency dated 8/4/24, indicated Resident (R1) was found on floor with head wound noted. Another resident (R2) was close to the scene and appeared to be leaving the area.</p> <p>On 8/8/24 at 11:10 a.m., video surveillance of the incident was viewed with the director of nursing (DON). The video showed R1 pushing a living room type chair across the television area of the unit. R2 was seated in a nearby chair and was speaking to R1 (no audio on video). R2 stood and began pushing the chair, with R1 still holding on to it, back across the room where it had been. As a result, R1 fell to the ground. As staff approached the area, R2 was seen talking and shaking his finger.</p> <p>During observation on 8/8/24 at 12:01 p.m., R1 was ambulating in the dining room. Staff assisted her to a table in the dining and R1 got up and followed staff. R1 then sat at a table with other residents at which time staff re-directed her back to a table by herself and put food in front of her. At 12:07, R1 was up wandering in the dining room again. At 12:43, R1 was observed ambulating in the television area of the unit where she set two pieces of bread on the arm of a chair and attempted to open the door to the kitchenette.</p> <p>During interview on 8/8/24 at 1:36 p.m., NA-A stated she was working the day of the 8/4/24, incident. NA-A stated she came out of another residents room and R1 was on the floor bleeding, adding she did not usually work on the unit and said she had been told R2 had pushed someone else recently and that resident had gotten seriously injured. NA-A said she had not been given any direction related to supervision of R1 or R2.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 8/8/24 at 1:48 p.m., NA-B stated on 8/4/24 she had been in another room and heard a crash and went out to assist. NA-B stated she was familiar with the residents on the unit and said the week prior R2 had pushed R1 down in the dining room. NA-B said R2 got mad when R1 was pushing chairs around and he would react. NA-B stated staff tried to re-direct R2 and tell him to go to his room but said it did not always work. NA-B stated after the incidents there were no new interventions or direction related to supervision other than to try to keep an eye on R2.</p> <p>During interview on 8/8/24 at 2:06 p.m., licensed practical nurse (LPN)-A stated R2's behaviors had changed and he seemed to be getting more territorial with his room and his walker. LPN-A stated R2 went through phases of going into other residents rooms and taking things. LPN-A added she was aware of the incident on 8/4/24, but was not given any specific details and when she worked, she tried to keep staff close by the residents to step in if needed. LPN-A stated R1 walked around and would pick up things to carry around with her but said R1 was not aggressive and she had never heard her raise her voice.</p> <p>During interview on 8/8/24 at 2:11 p.m., NA-C stated she was on break when the 8/4/24 incident had occurred and said she also heard there had been a similar incident the week prior. NA-C said on the p.m. shift the facility had safety aides who worked and said they tried to keep and eye on the residents.</p> <p>During interview on 8/8/24 at 2:32 p.m., LPN-B stated on 8/4/24 when the incident between R1 and R2 had occurred he had been called over from another unit to assist. LPN-B said R1 had fallen and sustained a head laceration. LPN-B stated staff had reported that R2 had been in the area when the fall occurred and had been hurrying away. LPN-B said R2 had other situations with residents in the past and said someone had fallen when in R2's room recently. LPN-B said there was no specific supervision plan for R2 and said staff just tried to keep an eye on him.</p> <p>During interview on 8/8/24 at 3:41 p.m., the DON acknowledged R2 had been involved in other resident to resident altercations and said they had placed a stop sign on his door because he was triggered by others wandering into this room. The DON stated they had recently ordered a different type of screen for R2's room. In regard to the incident on 8/4/24, DON stated the facility investigated and did not feel R2 had pushed R1 and did not intend to harm her. The DON said she felt R2 was only pushing the chair back to where it had come from. The DON said staff were monitoring R2 more closely since the incident but was not able to state what that meant and said she would have to talk with registered nurse (RN)-A. The DON further stated she was not aware R2 had pushed someone on 8/1/24.</p> <p>During interview on 8/8/24 at 4:01 p.m., RN-A stated she had written the progress note on 8/1/24, when R2 had pushed another resident and said the other resident was R1. RN-A said no one had witnessed the incident on 8/4/24 until the video surveillance had been reviewed. RN-A said R2 was not on one to one supervision but staff we really trying to keep an eye on him. RN-A stated after the incident on 8/4/24, nothing new had been implemented in regard to supervision.</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Facility policy Abuse Prevention Plan dated 9/5/19, identified abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish and described Willful: the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The policy indicated once suspected abuse, neglect, misappropriation of resident property, and/or financial exploitation has been identified, safety measures will be implemented to ensure the safety of the suspected vulnerable adult and other residents. Such safety measures may include the following: Responding immediately to protect the resident or alleged victim from further abuse and to protect the integrity of the investigation, Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment as needed, Moving a resident to another room or floor, Providing increased staff supervision of resident, as needed. Take any other appropriate corrective action not specifically listed above.		