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	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Vincent	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure care planned interventions to reduce the risk for falls were followed for 2 of 4 residents (R1, R3). This resulted in actual harm for R1 who fell and sustained a vertebral fracture. Findings include: R1's Resident Face Sheet indicated she admitted to the facility 1/30/24. Diagnosis included dementia, fracture of T (thoracic) 11- T12 vertebrae, difficulty walking, muscle weakness and age related osteoporosis. R1's quarterly Minimum Data Set (MDS) dated [DATE], identified moderate cognitive impairment. The MDS indicated R1 required partial to moderate assistance and did not ambulate due to medical condition or safety concerns and had no falls since the prior assessment. R1's assessment for Fall Risk and Functional Limitation dated 4/22/25, identified intermittent confusion, balance problem while standing, impaired mobility and indicated R1 utilized a wheelchair. The assessment score of 16 indicated a high risk for falls. R1's care plan dated 5/16/25, identified a self-care deficit and indicated she needed assistance with bed mobility, transfers, ambulation and locomotion due to a history of a fall with hip fracture. The care plan identified a high risk for falls and indicated all standard fall interventions were in place. An undated, untitled nursing assistant (NA) care guide directed staff to provide extensive assistance of one to two staff with transfer and directed staff to utilize a wheelchair for transport. R1's Resident Progress Notes indicated the following: -5/30/25, Nurse was called to the hallway outside of R1's room where she was on the floor sitting with NA-A behind her, and both legs in front of her. Per NA-A, R1 fell around the corner. R1 complained of pain to her buttocks. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-5/31/25, R1 was experiencing severe back pain rated 9/10 on pain scale. R1 was clenching her fists and grimacing and refused to roll over due to pain. New order received to increase Tramadol (used for the management of moderate to moderately severe pain) to 50 milligrams (mg) every four hours as needed. -6/1/25 at 10:58 a.m., R1 continued to complain of pain in her back. Family member requested R1 be sent to the emergency department (ED) for further evaluation. 6/1/25 at 1:45 p.m., received call from ED staff who reported R1 sustained a T12 compression fracture (a type of fracture where a vertebra in the spine is compressed or collapses). 3:05 p.m., R1 returned from ED with the following orders: Start taking Hydrocodone-acetaminophen (combination prescription medication used to treat moderate to severe pain) 5 mg-325 mg, 1 tablet every six hours as needed for moderate or severe pain if not controlled by Tramadol. R1's ED Provider Note dated 6/1/25, indicated she presented to the ED for pain. The note indicated R1 experienced constant pain that started two days prior as a result of a fall. Pain was present in the lumbar spine and symptoms were aggravated by bending, twisting and certain positions. Tramadol provided no relief. Lumbar computed tomography scan (a medical imaging test that uses X-rays and computers to create detailed images of the lower spine) showed a T12 compression fracture. During interview on 6/4/25 at 6:33 p.m., registered nurse (RN)-A stated staff had reported R1 was in the hallway and started to slowly fall so NA-A lowered R1 to the ground. RN-A stated R1 did not typically ambulate, but NA-A had been walking with her at the time of the fall. RN-A stated NA-A had not used a transfer belt when walking with R1. RN-A said R1's family did not want her walking after she sustained a hip fracture the previous year and said the NA care sheet directed staff to utilize a wheelchair. During interview on 6/4/25 at 6:50 p.m., the assistant director of nursing (ADON) stated NA-A should have known not to ambulate with R1 and should have utilized a transfer belt. The ADON said NA-A received education following the incident and all staff received training on following resident fall interventions. During interview on 6/5/25 at 8:18 a.m., NA-A stated on 5/30/25, at approximately 5:00 p.m., she had been doing rounds on the unit. NA-A said she went to R1's room to bring her to the dining room and said she had been distracted and forgot about the transfer belt. NA-A said she got R1 up and out to the hallway and said R1 was holding on to the walker with one hand and the hand rail with the other hand. NA-A said after they got about four feet from R1's room, R1 stopped and said it was too far, then let go of the railing. NA-A said that was when she realized she had forgotten the gait belt so she somewhat grabbed R1 and went to the floor with her. NA-A stated she had been working at the facility for almost four months and said she had not been trained on the care plan when she started but was trained following the fall incident. During interview on 6/5/25 at 9:05 a.m., NA-B stated she had been working the night of R1's fall. NA-B said NA-A went to get R1 up for dinner and said NA-A did not look at the care guide and thought R1 could walk. NA-B said R1 had not walked with staff since she had broken a bone in the past. NA-B said NA-A also had not used a transfer belt when walking with R1. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During interview on 6/5/25 at 12:07 p.m., NA-E stated R1 participated in a range of motion program but said she did not ambulate with staff. NA-E said the last time he had seen R1 walk with staff was the previous year. During interview on 6/5/25 at 12:13 p.m., NA-F said R1 fell because the staff person walking with her did not use a transfer belt. NA-F said he had never seen staff walk with R1 and said the care guide said to use the wheelchair for long distances. R3's Resident Face Sheet indicated he admitted to the facility 4/17/25. Diagnosis included traumatic subdural hemorrhage with loss of consciousness, Alzheimer's disease, maxillary fracture (a break in the bones surrounding the maxillary sinus, which are air-filled spaces in the cheekbones), fracture of lateral orbital wall (break in the outer wall of the eye socket) of right eye, muscle weakness and repeated falls. R3's assessment for Fall Risk and Functional Limitation dated 5/5/25, indicated he was disoriented, required the use of assistive devices and had impaired mobility. The assessment identified a fall score of 20 which indicated high risk. R3's 5-day MDS dated [DATE], identified severe cognitive impairment and indicated he required supervision for transfers and partial to moderate assistance for toileting. The MDS indicated ambulation was not attempted due to medical condition or safety concerns and indicated he had one fall since the prior assessment. R3's care plan dated 5/20/25, identified impaired physical mobility related to cognitive decline secondary to dementia. The care plan directed staff to provide assistance from two caregivers during all transfers and ambulation. The care plan further identified a high risk for falls due to a history of falls. Fall interventions included; remove leg rests when not pushing R3 in the wheelchair, auto lock brakes on wheelchair, and transfer belt at all times. R3's NA care guide, undated identified fall interventions that included slip grip to wheelchair and recliner chair. R3's Resident Progress Notes indicated the following: -5/1/25, progress note indicated, R1 had been leaning to his right side in the wheelchair and slid out of the chair. (no time indicated) -5/1/25, R3 had a second fall, progress note indicated at approximately 2:40 p.m., R1 had an unwitnessed fall from his wheelchair, landing on the floor and striking his head. R3 was found lying on his left side the hallway. R3 verbalized pain to his forehead. Staff noted a raised area on R3's forehead. 5/1/25, Interdisciplinary team (IDT) reviewed the falls. Intervention to ensure slip grip was applied when in wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-5/5/25, progress note indicated R3 returned from the hospital where he had been admitted on [DATE]. Hospital diagnosis included acute subdural hematoma (a life-threatening condition where blood collects between the brain and its outer lining, the dura mater, following a head injury), acute non-displaced fractures of right maxillary sinus and right lateral orbit, and metabolic encephalopathy (a change in how your brain works due to an underlying condition), likely due to urinary tract infection. -5/6/25, progress note indicated IDT reviewed fall and implemented Slip Grip to recliner chair. -5/16/25, progress note indicated R3 experienced a fall from a wheelchair. Staff determined the wheelchair utilized at the time of the fall did not belong to R3. -5/18/25, R3 had an unwitnessed fall in his room. -5/25/25, R3 had a fall in the dining room. -5/27/25, R3 had two falls, the first fall, R3 was found on the floor in his room. The second fall R3 fell attempting to ambulate in the television room. -6/1/25, R3 fell after attempting to stand up from his wheelchair and sustained a laceration above his right eye. -6/2/25, R3 had an unwitnessed fall and was found on his back with his leg tangled in the footrest of his wheelchair. During interview on 6/5/25 at 11:47 a.m., NA-C stated R3 required one person to transfer and could walk using a gait belt. When asked about fall interventions, NA-C was not sure where to look. NA-C pulled the resident care guide out of her pocket, looked at it and said, I'm not really seeing a lot, then said no interventions were listed on the care guide. (interventions were listed on the back of care guide) During interview on 6/5/25 at 11:51 a.m., NA-D said they used two staff to assist R3 due to behaviors. Regarding fall interventions, NA-D said staff just monitored him closely and said he had a motion detection device in his room. During observation and interview on 6/5/25 at 11:59 a.m., R3 was seated in a chair in the television area of the unit with his legs crossed and his eyes closed. R3 was seated on a soaker pad and did not appear to have slip grip underneath him. RN-B was interviewed and acknowledged no slip grip had been placed under R3 in the chair. RN-B stated R3 was care planned to have slip grip in his wheelchair and his recliner chair. RN-B said he should have it in any chair he was sitting in. RN-B stated fall interventions were on the NA care guides. The care guide was reviewed with RN-B and fall interventions, including the slip grip were listed on the backside of the paper. Facility policy Comprehensive Assessment and Care Planning dated 9/27/23, indicated the facility should use the results of the assessment to develop, review and revise the residents person-centered comprehensive care plan. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	All person-centered care plan interventions will be implemented by qualified personnel. Interventions may be communicated through the electronic health record, resident profile, assignment sheets, and/or verbal communication.