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	07/10/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to protect the residents right to be free from physical abuse by other residents for 2 of 3 residents (R2, R3) when care plan intervention to adequately increase supervision to protect residents from abuse were not implemented and behaviors were not investigated or documented with detail to assist in determining possible antecedents of the negative behavior. Additionally, the facility failed to monitor R3 for mood and behavioral changes following a resident-to-resident abuse incident which resulted in minor injuries and increased withdrawal. R2's Resident Face Sheet indicated she admitted to the facility 10/19/23. R2's diagnosis included Alzheimer's disease, insomnia and dementia with behavioral disturbance.R2's quarterly Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment and indicated she displayed wandering behaviors 4-6 days during the assessment period. The MDS indicated R2 ambulated independently.R2's Vulnerable Adult assessment dated [DATE], indicated she did not have a history of abuse toward others or self abuse. R2 had physical limitations and cognitive deficits that made her susceptible to abuse. R2 had behaviors that made her susceptible to abuse to self or others and had communication limitations. R2's care plan dated 6/30/25, identified her as a vulnerable adult and indicated if she became violent or aggressive staff should implement interventions to minimized risk to herself or others. The care plan indicated she had exhibited physical aggression toward others and indicated she had slapped another resident on 10/4/24 and 10/11/24, had pinched another resident on 10/6/24, and pushed another resident on 6/30/25. The care plan directed staff to provide close supervision and gently guide her away if she was observed in close proximity to peers, especially when entering others personal space or rooms and observe her closely to identify specific triggers that may lead to aggression. The care plan further directed staff to provide sensory items and/or baby doll and stroller when R2 became agitated. The care plan indicated R2 exhibited inappropriate behaviors such as wandering into other residents rooms and taking things that didn't belong to her. R2's Resident Progress Notes identified the following:5/11/25, R2 had family visit. After they left R2 appeared to be upset. R2 had been in and out of other residents rooms, tried to take a blanket off someone who was using it and was walking around the dining room trying to take food and drinks off of other residents trays.6/19/25, R2 was standing in the dining room to the left of a male resident. R2 was observed interacting with newspapers on the table and not engaging with male resident. Male resident reached out and struck R2 on the elbow with a closed fist. Staff removed R2 from the area. 6/30/25, R2 found on the floor of another residents (R3) room. The other resident stated R2 came to her door and she tried to push her out and said R2 pushed back. R2 had a bump on the back of her head. 6/30/25, Due to resident to resident altercation, R2 would remain under constant supervision due to ongoing boundary intrusiveness.7/3/25, R2 remained one to one with staff. During observation on 7/10/25 at 11:13 a.m., R2 was ambulating independently on the unit. R2 was following a female resident. R2 had newspapers in her hand and was touching the other resident with them. The other resident repeatedly stated, don't touch me. A staff member was standing with her back to the room, down the hall. Two other staff walked out of the bathroom with a different resident. No staff were in the area to intervene. At 11:20 a.m., the other resident propelled herself out of her room. R2 walked over and placed her hands on the other residents wheelchair. The other resident stated, no, no, no, don't touch me. R3's Resident Face Sheet indicated she admitted to the facility on [DATE]. Diagnosis included dementia without behavioral disturbance, agitation, Alzheimer's disease and anxiety. R3's quarterly MDS dated [DATE], identified severe cognitive impairment and indicated she displayed physical, verbal and other behaviors 4-6 days of the assessment period and wandering behaviors 1-3 days. The MDS indicated R3 ambulated independently.R3's care plan dated 6/30/25, identified her as a vulnerable adult. The care plan indicated if R3 got violent or physically aggressive staff would implement interventions to minimize risk to self or others. Facility to report and investigate any allegations of suspected abuse. The care plan indicated R3 had been a victim of another residents physical aggression. The care plan directed a mesh screen to her door and directed staff to monitor for behavioral changes indicating fear, withdrawl or anxiety and adjust care accordingly. The care plan identified behavioral symptoms that included hallucinations/delusions. R3's Vulnerable Adult assessment dated [DATE], indicated she did not have a history of any type of abuse toward others or self. R3 did not have physical limitation which made her susceptible to abuse, but did have cognitive deficits. The assessment further indicated R3 did not display behaviors that made her susceptible

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and document review the facility failed to ensure timely reporting to the state agency (SA) of a significant medication error for 1 of 3 residents (R1) reviewed for medication errors and failed to ensure timely reporting of an incident of resident to resident abuse for 2 of 3 residents (R2,R3) reviewed for abuse. Findings include:R1's care plan dated 6/27/25, identified the use of high-risk medications for pain. The care plan directed staff to administer medications as ordered and assess for side effects. R1's Physician Order Report dated 6/1/25 through 6/30/25, identified the following medications. -6/6/25, OxyContin 15 milligrams (mg) by mouth every 12 hours.-6/17/25, Oxycodone 5mg every six hours as needed for severe pain.-6/28/25, MS Contin (morphine) 30mg every twelve hours. Discontinued 6/29/25. Provider note dated 6/27/25, indicated Oxycontin had been denied due to health care plan. An emergency refill was approved through the weekend. A prescription dated 6/27/25, indicated do not fill until 6/30/25. MS Contin 30 mg oral tablet extended release by mouth every 12 hours. R1's Medication Administration History dated 6/1/25 through 6/30/25, indicated the following medications were administered:-MS Contin 30mg, 6/28/25 at 12:00 p.m., 6/29/25 at 12:00 a.m. and 6/29/25 at 12:00 p.m.-OxyContin 15mg, 6/2825 at 8:00 a.m., 6/28/25 at 8:00 p.m., 6/29/25 at 8:00 a.m. 8:00 p.m. dose not administered due to condition. -6/30/25, 2:20 a.m., R1 was semi-alert but unresponsive verbally and only able to open eyes partially. R1's pulse was 116 beats per minute; oxygen saturation level was 56 percent on room air. On-call nurse practitioner (NP) was updated and directed staff not to call 911 due to resuscitation status. Family was updated and came to see R1 and requested she be sent to the emergency department (ED). R1's hospital notes dated 6/30/25, indicated R1 admitted for altered mental status and hypoxia (a condition where the body, or a specific part of it, doesn't receive enough oxygen). Apparently have both oxycodone and morphine last afternoon for pain. No Narcan was given and R1 was hypoxic on arrival to ED and barely responded to verbal commands. Her baseline was alert and awake. The current episode started from one to two hours ago and the problem had not changed. Associated symptoms included confusion, somnolence (excessive sleep or drowsiness) and unresponsiveness. R1 responded to three doses of Narcan. Was alert and awake after Narcan but continued to be hypoxic. Started antibiotic to cover aspiration pneumonia secondary to obtundation from opioid overdose. A report to the SA indicated the medication error was reported on 7/1/25, at 6:43 p.m. During interview on 7/10/25 at 11:00 a.m., the director of nursing (DON) stated when a significant medication error was identified it should be reported to the SA. The DON said she felt like she had to do a little more digging do determine if the medication error was significant and when she determined it was, she reported the error. The DON said when she learned R1 had been admitted to the hospital it was determined to be a significant error. R2's Resident Face Sheet indicated diagnosis included Alzheimer's disease, insomnia and dementia with behavioral disturbance. R2's Resident Progress Notes dated 6/30/25, indicated R2 was found on the floor of another residents (R3) room. The other resident (R3) stated R2 came to her door, and she tried to push her out and said R2 pushed her back. R2 had a bump on the back of her head. R3's Resident Face Sheet indicated diagnosis included dementia without behavioral disturbance, agitation, Alzheimer's disease and anxiety. R3's Resident Progress Note dated 6/30/25, indicated per trained medication aide (TMA), R3 came out of her room asking for assistance. TMA and another caregiver noted R3's right eye was black and blue and swollen and her lip was swollen with a small amount of blood noted. R3 brought the staff to her room where another resident (R2) was lying on the bathroom floor. When asked what happened, R3 stated the other resident was trying to come into her room so she pushed her away and said the other resident pushed back and they both fell on the floor. An additional Progress Note dated 6/30/25, indicated the incident occurred at 6:40 a.m. A report to the SA indicated the resident-to-resident altercation had been reported 6/30/25 at 3:16 p.m. During interview on 7/10/25 at 1:29 p.m., the DON stated the incident had not been reported to the SA in the required two-hour time frame. The DON said staff had called her at home and she went to the facility and reported as soon as she could. Facility policy Abuse Prevention Plan dated 7/21/22, indicated staff would notify building charge immediately any reports of possible abuse, neglect, misappropriation or exploitation. The charge would immediately notify the administrator, DON and social services. If the event that caused suspicion involves abuse or results in serious bodily injury the individual is required to report to the SA immediately, but no later than two hours after forming the suspicion. Abuse was described as: the willful infliction of injury. Neglect described as: Failure of the facility, employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain or

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to ensure residents remained free from significant medication errors. This resulted in actual harm to R1 who was administered opioid medications prior to the prescribed date resulting in hypoxia, confusion and unresponsiveness and required the use of Narcan (used to reverse the effects of an opioid overdose).Findings include: A report to the state agency dated 7/1/25, indicated R1 had a visit with the palliative care provider on 6/27/25. The provider was informed that the R1's insurance had denied Oxycontin which R1 had been receiving for management of significant pain from fractures that occurred prior to admission to SNF (skilled nursing facility). R1's provider, nurse practitioner (NP)-A, stated that she made numerous calls regarding this patient on Friday afternoon once she received notification of the denied coverage of the Oxycontin from the insurance. After lengthy calls with the insurance provider and pharmacy it was determined the Oxycontin would be extended until they could work through a prior authorization of Morphine for pain management. The provider had to write an order for Morphine to initiate the prior authorization process. However, the order indicated not to fill until on or after 6/30/25. The night nurse received Morphine from the pharmacy on 6/28/25, around 1:00 a.m. A call was placed to the pharmacy as the facility did not have an order. The pharmacist confirmed the order, indicated the signed order would be sent to the facility. Upon receipt, the night nurse entered the order into the electronic record on 6/28/25 at 1:34a.m. R1 received Morphine while continuing to receive OxyContin. R1's Resident Face Sheet indicated she admitted to the facility on [DATE], diagnosis of osteoporosis with fractures of left and right lower leg and left clavicle. R1's admission Minimum Data Set (MDS) dated [DATE], identified moderate cognitive impairment, dependent on staff for transfers and had almost constant severe pain. R1's care plan dated 6/27/25, identified the use of high-risk medications for pain. The care plan directed staff to administer medications as ordered and assess for side effects. R1's Physician Order Report dated 6/1/25 through 6/30/25, identified the following medications. -6/6/25, OxyContin 15 milligrams (mg) by mouth every 12 hours. -6/17/25, Oxycodone 5mg every six hours as needed for severe pain.-6/28/25, MS Contin (morphine) 30mg every twelve hours. Discontinued 6/29/25. Provider note dated 6/27/25, indicated Oxycontin had been denied due to health care plan. An emergency refill was approved through the weekend. A prescription dated 6/27/25, indicated do not fill until 6/30/25. MS Contin 30 mg oral tablet extended release by mouth every 12 hours. R1's Medication Administration History dated 6/1/25 through 6/30/25, indicated the following medications were administered. -MS Contin 30mg, 6/28/25 at 12:00 p.m., 6/29/25 at 12:00 a.m. and 6/29/25 at 12:00 p.m.-OxyContin 15mg, 6/2825 at 8:00 a.m., 6/28/25 at 8:00 p.m., 6/29/25 at 8:00 a.m. 8:00 p.m. dose not administered due to condition. R1's Resident Progress Notes identified the following:-6/28/25, Fax received from pharmacy for MS Contin. Order placed in electronic record. MS Contin 30 mg oral tablet extended release every 12 hours.-6/29/25, 2:52 p.m., R1 was very groggy and not eating or drinking. Writer noted R1 was receiving both OxyContin and MS Contin. Call placed to pharmacy who confirmed R1 should not be receiving both medications at the same time. MS Contin was not supposed to be started unless payment authorization was not received for OxyContin.-6/29/25, 4:07 p.m., R1 resting in bed. She would respond by opening her eyes a little with gentle touch and calling her name.-6/30/25, 2:20 a.m., R1 was semi-alert but unresponsive verbally and only able to open eyes partially. R1's pulse was 116 beats per minute; oxygen saturation level was 56 percent on room air (normal range for oxygen saturation is 95-100). On-call nurse practitioner (NP) was updated and directed staff not to call 911 due to resuscitation status. Family was updated and came to see R1 and requested she be sent to the emergency department (ED). R1's hospital notes dated 6/30/25, indicated R1 admitted for altered mental status and hypoxia (a condition where the body, or a specific part of it, doesn't receive enough oxygen). Apparently had both oxycodone and morphine last afternoon for pain. No Narcan was given and R1 was hypoxic on arrival to ED and barely responded to verbal commands. Her baseline was alert and awake. The current episode started from one to two hours ago and the problem had not changed. Associated symptoms included confusion, somnolence (excessive sleep or drowsiness) and unresponsiveness. R1 responded to three doses of Narcan. Was alert and awake after Narcan but continued to be hypoxic. Started antibiotic to cover aspiration pneumonia secondary to obtundation from opioid overdose. During interview on 7/9/25 at 2:14 p.m., pharmacist (P)-A stated the potential negative effects of too much opioid medication included respiratory distress, increased sedation. Tachycardia (a condition where the heart beats faster than normal, typically over 100 beats per