

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 03/27/2025
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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943</p> <p>Based on interview and document review, the facility failed to follow through on a grievance regarding missing clothing for 1 of 1 resident (R9) reviewed for grievances.</p> <p>Findings include:</p> <p>R9's admission Minimum Data Set (MDS) dated [DATE], identified R9 had a severe cognitive impairment and diagnoses included Alzheimer's disease and dementia.</p> <p>During a phone interview on 3/24/25 at 3:07 p.m., family member (FM)-A stated half of R9's clothing and slippers were missing. The first thing staff asked FM-A was if FM-A labeled the clothing. FM-A stated she was unaware she needed to label the clothing prior to bringing it to the facility and was told to bring R9's clothing to the nurses' desk so that's what FM-A did. The clothing and slippers went missing from there. FM-A stated she had to re-buy all the missing items, was not reimbursed and would no longer allow R9's clothing to be washed at the facility.</p> <p>During an interview on 3/27/25 at 11:05 a.m., licensed practical nurse (LPN)-B stated FM-A did report R9 had missing clothing. LPN-B called the laundry and asked that laundry staff look for the missing items, but they were not found. FM-A stated she would wash R9's clothing from then on. LPN-B had never heard of anyone ever making a report or anything for missing items.</p> <p>During an interview on 3/27/25 at 11:07 a.m., registered nurse (RN)-E stated when a resident or family member reported missing items. Staff should start looking for it and report it to the social worker or the unit manager. For clothing, staff notified laundry and housekeeping, so everyone was looking for the missing item. Also, there was a rack of unlabeled clothing that they can look through and usually the missing item is found.</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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/27/25 at 11:47 a.m., the social services (SS)-A stated staff usually contacted SS-A or send an email to all staff so the item could be searched for. Then, SS-A went to laundry and/or took the family member or resident to the laundry to look through the lost and found to see if the item could be found. SS-A did not necessarily fill out a grievance form. SS-A would ask the resident or family member if they wanted to file a grievance, but they usually say they just want to keep an eye out for it. SS-A stated she was aware R9 had some missing clothing items. SS-A brought FM-A to the laundry to look through the lost and found and some items were found, and some items weren't. FM-A had given the clothing to a nurse who said they were bringing the clothing to laundry to get labeled, but the items went missing from there. SS-A did not fill out a grievance for R9.</p> <p>During an interview on 3/27/25 at 1:29 p.m., the director of nursing (DON) stated missing items was an area where the facility had room to improve. Usually, an email was sent out for all staff that indicated what was missing and staff responded with what was or wasn't found. The DON's understanding was the social worker brought that information to the administration or, at least, reached out to the family with how the family wanted to proceed. Usually, the administration instructed to replace those items, bring the receipt and the administration would reimburse those funds. The DON stated there was no documentation to show that was done for R9 and/or FM-A. All missing items are personal to the residents and staff needed to do their due diligence to find those items or to see if there was a pattern in a specific area. It was important to the residents and staff needed to be mindful of that.</p> <p>The facility Missing Items policy reviewed 8/4/17, identified the following:</p> <ol style="list-style-type: none"> 1. All personal were responsible for reporting missing items to the supervisor staff prior to their end of shift. 2. Any items found that could not be identified, were reported to the supervisory staff and stored until the owner could be determined. 3. Staff worked to locate the missing items. 4. If items were not located, staff worked with the resident or resident representative to determine next steps. 		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943</p> <p>Based on observation, interview and document review, the facility failed ensure their infection control surveillance contained all data to effectively track, trend, analyze infections with the potential to affect all residents residing in the facility; and the facility failed to ensure enhanced barrier precautions and standard precautions for 1 of 2 residents (R140) reviewed for wound care; and failed to ensure contact precautions were followed for 1 of 3 residents (R75) reviewed for transmission-based precautions.</p> <p>Findings include:</p> <p>Surveillance:</p> <p>The Infection Prevention Line Listing dated March 2025, identified columns labeled the following: all units, ID number, resident name, age, sex, room, infection site, date/lab pathogen, date/symptoms, predisposing factors, date isolation began, date isolation ended, date/treatment, appropriate yes/no, in-house acquired, resolved yes/no. However, the line listing identified twelve resident names, age, sex and room number but failed to identify any other information.</p> <p>The Infections excel spreadsheet dated 3/4/25 to 3/20/25, identified the following: Two carbuncles (Norovirus infection can cause severe vomiting and diarrhea that start suddenly. Noroviruses are highly contagious. They commonly spread through food or water that is contaminated during preparation or through contaminated surfaces. Noroviruses can also spread through close contact with a person who has norovirus infection.)</p> <ul style="list-style-type: none"> - 8 UTIs. - 1 septic arthritis - 1 bronchitis - 2 respiratory infections - 1 pneumonia <p>All listed were treated with medication.</p> <p>R21:</p> <p>R21's admission Minimum Data Set (MDS) dated [DATE], identified R21 was cognitively intact and had diagnoses that included irregular heart rate, left femur fracture, fibromyalgia, left arm fracture, and right wrist fracture. R21 was frequently incontinent of bladder and had a colostomy (a surgical procedure that creates an opening for the colon through the abdominal wall. It is done when there is a problem with the colon or a disease affecting it).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>R21's nursing progress notes on 3/01/25 at 10:38 a.m., R21 was complaining of being weak, tired, nauseated, diarrhea, stomach pains. R21 was having the dry heaves. Colostomy bag was emptied. Toileted and put in bed per her request. R21 did try to eat oatmeal but that wasn't what she wanted or worked with her stomach. Has refused her morning medications.</p> <p>During an interview on 3/25/25 at 5:01 p.m., licensed practical nurse (LPN)-B stated that weekend R21 complained of diarrhea, abdominal pain and a low-grade temperature. Staff treated it like it was norovirus (Norovirus infection can cause severe vomiting and diarrhea that start suddenly. Noroviruses are highly contagious. They commonly spread through food or water that is contaminated during preparation or through contaminated surfaces. Noroviruses can also spread through close contact with a person who has norovirus infection.) The first day R21's diarrhea was frequent; sometimes every hour with some watery and some formed feces.</p> <p>R75:</p> <p>R75 discharge return anticipated MDS dated [DATE], identified R75 had a mild cognitive impairment and had diagnoses that included traumatic head injury and chronic obstructive pulmonary disease (COPD). R75 was frequently incontinent of bladder and bowel. R75 required substantial to maximum assistance with toileting.</p> <p>R75's nursing progress note dated 3/21/25 at 4:59 p.m., identified R75 returned to the facility after a hospitalization . R75 had been admitted to the hospital on 3/14/25 due to right lower lobe pneumonia and a complicated urinary tract infection (UTI). R75 tested positive for norovirus on 3/20/25 due to diarrhea. Contact precautions were initiated.</p> <p>The Infection Prevention Line Listing dated March 2025 and The Infections excel spreadsheet dated 3/4/25 to 3/20/25 , failed to identify R21 nor R75's symptoms and treatments.</p> <p>During an interview on 3/26/25 at 2:36 p.m., registered nurse (RN)-A stated she was the facility's infection prevention nurse as well as the Station 240-unit manager. RN-A dedicated eight hours a week to the infection prevention program but tried to keep up with infection signs/symptoms surveillance daily. The facility used an excel spreadsheet where any licensed staff could enter information when a resident was started on an antibiotic or antiviral. From there, RN-A would enter that information on the line listing form and do mapping of the infections at the end of the month. Additionally, the unit managers would read nursing progress notes daily to look for signs of infection. RN-A stated she was unaware of R21's symptoms but staff were generally aware of residents with symptoms such as nausea, vomiting and/or diarrhea. Rarely would the facility have a diagnosis correlating to the symptoms unless there were laboratory tests to confirm it. However, unless a resident was prescribed a treatment, such as antibiotics, the resident would not be added to the surveillance.</p> <p>During an interview on 3/27/25 at 12:09 p.m., the director of Nursing (DON) stated all signs and symptoms of potential infections should be tracked and evaluated timely to find trends earlier to try to prevent the spread of infection and keep it contained.</p> <p>The facility policy Surveillance Reporting revised 8/2023, identified once surveillance was completed, the data was collected and analyzed, and the significance was summarized. The resulting information should be shared with those who assist in the infection prevention and may include internal and external sources.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>1. The IP performs on-going surveillance and investigation into all infections within the facility.</p> <p>2. Once the surveillance is completed, the data collected is analyzed and summarized. It is then shared with the parties that assist with infection prevention in facilities, or if indicated external agencies.</p> <p>3. If infection trends are noted, or there has been a break in infection prevention standards, the 1P will educate the associates noted in the trend or break, put an action plan in place to monitor for adherence lo standards, and report the results of both the trend and/or break in standards, as well as the action plan to tile Quality Council for further recommendations/comments.</p> <p>4. Internal reporting may include, but is not limited to:</p> <ul style="list-style-type: none"> a. Resident and /or their significant support systems and family members b. Nursing c. Admitting d. Therapy e. Life enrichment/activities f. Environmental Services g. Maintenance h. Culinary i. Administration j. Quality Council <p>6. The IP must know what to report, how to report, and who must be informed.</p> <p>7. Repo11ing requirements vary by state and may include reporting healthcare associated infections, community-associated infections, and infectious/communicable diseases.</p> <p>8. As part of public reporting, each IP will make contact with the public health professionals who may assist the facility in time or need.</p> <p>Enhanced Barrier and Standard Precautions:</p> <p>R140</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>R140's admission MDS dated [DATE], identified R140 was cognitively aware and had diagnoses included osteomyelitis of sacral and sacrococcygeal vertebra (a rare infection in your spine. It happens when bacteria or fungi infect your vertebrae (spine bones). The infection can start in your spine if the germs get in a wound or surgery site. It can also spread to your spine from somewhere else in your body. You'll need medication for several weeks to kill the infection. Vertebral osteomyelitis can damage your affected vertebra and the tissue around it in your spine.), type 2 diabetes, chronic kidney disease and weakness. R140 was at risk for pressure ulcers and had one stage 4 pressure ulcer.</p> <p>R140's care plan revised 3/13/25, identified R140 was at risk for alteration of skin status due to weakness, pain, type 2 diabetes and current treatment for osteomyelitis. Interventions included a special mattress, offloading when in bed, barrier cream applied to dry areas as needed, and a wheelchair cushion. R140 require a wound care treatment plan as follows: wound vac per orders and wet to dry dressings as needed. However, the care plan failed to identify R140's need for enhanced barrier precautions.</p> <p>R140's physician order dated 3/22/25, identified R140 had a wound vac to sacrum, change Tuesday, Thursday and Saturday and pressure set to -125.</p> <p>During an interview on 3/24/25 at 4:35 p.m., R140 stated he had a sore on his butt that was awful. R140 stated the wound went all the way to the bone and the nurses were not really trained in how they take care of it. R140 had to direct staff, or staff got to a point and would have to start over.</p> <p>During an observation on 3/25/25 at 9:41 a.m., R140's door to his room had an enhanced barrier precautions (EBP) sign on his door with a personal protective equipment cart outside his room. RN-B changed R140's wound vac dressing while licensed practical nurse (LPN)-A assisted. Prior to starting the dressing change RN-B and LPN-A entered R140's room without putting on a gown. Without gloves, RN-B removed R140's catheter bag from under R140's wheelchair and placed it on R140's bed frame.</p> <p>- At 9:43 a.m., LPN-A placed R140's walker in front of R140. With verbal cues and stand by assistance, R140 stood, turned and sat on his bed.</p> <p>- 9:45 a.m., RN-B nor LPN-A put on a gown. RN-B placed R140's wound vac on bed and removed the wound vac cover. RN-B put on gloves then clamped and disconnected the wound vac tubing. RN-B and LPN-A assisted R140 to pull down his pants.</p> <p>- 9:49 a.m., RN-B removed R140's soiled dressing. RN-B stated the dressing had bloody, brown drainage. RN-B removed her gloves, but did not use hand sanitizer before putting on new gloves and pulled foam from R140's wound. RN-B removed her gloves, but did not use hand sanitizer before putting on new gloves and cleansed the wound with a 4 inch by 4 inch gauze and wound cleanser. RN-B stated the wound was 25% slough (Slough in wound healing refers to dead tissue within a wound, often appearing as a yellow, tan, or white fibrous material) with some granulation (Granulation tissue heals the wound by filling in the wound from the base, moving upward) and a new undermined(caused by erosion under the wound edges, resulting in a large wound with a small opening) area.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- 9:52 a.m., RN-B put on new gloves without using hand sanitizer and a portable electronic tablet to take photos of R140's wound, LPN-A used a gloved hand to pull back R140's right buttock to allow for a clear wound photo. RN-B was leaning on R140's bed with the linens touching RN-B's forearms and the front of RN-B's uniform. RN-B removed her soiled gloves but did not use hand sanitizer and used a clipboard and pen to write down R140's wound measurements.</p> <p>- 9:54 a.m., RN-B opened the new wound vac dressing and laid it on R140's bed. RN-B did not place a clean surface for the dressing to lie on.</p> <p>- 9:55 a.m., RN-B put on clean gloves and replaced R140's wound vac dressing. RN-B nor LPN-A wore a gown and hand sanitizer was not used between soiled and clean gloves.</p> <p>- 10:18 a.m., RN-C entered R140's room without a gown or gloves, looked at R140's wound dressing and left the room. RN-B disposed of the dressing packaging, removed her soiled gloves and fastened R140's incontinence brief. RN-B and LPN-A assisted R140 to pull up his pants.</p> <p>- 10:22 a.m., RN-B and LPN-A exited R140's room. RN-B took the electronic tablet, clipboard and pen without using a sanitizing wipe.</p> <p>During an interview on 3/25/25 at 10:29 a.m., LPN-A stated R140's EBP were only for catheter/ostomy care. Staff did not need to wear a gown any other time.</p> <p>During an interview on 3/25/25 at 10:29 a.m., RN-B stated R140's EBP were for catheter cares and not for the wound care because R140 had a wound vac. RN-B stated gowns should be worn during wound care yea, probably.</p> <p>During an interview on 3/25/25 at 10:29 a.m., RN-C stated staff were expected to wear a gown and gloves when entering R140's room, to perform hand hygiene (hand washing or hand sanitizer) when removing soiled gloves and were expected to clean all equipment when exiting the room to prevent potential infections.</p> <p>During an interview on 3/26/25 at 2:57 p.m., RN-A stated staff were educated that when a sign was on a resident's door and there was a PPE cart there, staff were expected to put on PPE. The facility even implemented reference cards for the staff name badge, so staff always had access to what was needed and when. RN-A could not say why staff did not wear the appropriate PPE during a wound vac change because it just screams the need for PPE.</p> <p>During an interview on 3/25/25 at 10:31 a.m., the DON stated staff were expected to put on a gown and gloves when entering R140's room, use hand sanitizer between clean and dirty gloves and either leave the equipment in the room or clean it when leaving the room to prevent possible infections.</p> <p>The facility policy Hand Hygiene revised 2/5/20, identified there are situations in nursing homes and assisted living which may lead to a higher rate of infectious disease than a person living in their own home. Therefore, associates in these settings have a special concern to prevent the spread of infection through proper hand hygiene. All associates are accountable including those not involved in direct care. Clean hands are the single most important factor to stop the spread of infection. Hand must be washed with soap and water when hands are visibly soiled, after skin contact with blood or body fluids and after exposure to infectious materials.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The CDC dated 6/28/24, identified Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).</p> <p>The facility policy Enhanced Barrier Precautions undated, identified Enhanced Barrier Precautions (EBP) is a strategy in nursing homes to decrease transmission of CDC-targeted and other epidemiological important multidrug-resistant organisms (MDROs). EBP will be used for residents actively infected or colonized with CDC-targeted and other epidemiologically important MDROs. Additionally, residents at risk for MDROs, specifically those with an indwelling medical device and/or chronic wounds requiring a dressing will be required to use EBP.</p> <p>Transmission Based Precautions</p> <p>Centers for Disease Control and Prevention (CDC) Appendix A: Type and Duration of Precautions Recommended for Selected Infections and Conditions updated 2/7/25, identified norovirus required the use of contact precautions for a minimum of 48 hours after the resolution of symptoms or to control institutional outbreaks. Persons who clean areas heavily contaminated with feces or vomitus may benefit from wearing masks since virus can be aerosolized from these body substances; ensure consistent environmental cleaning and disinfection with focus on restrooms even when apparently unsoiled. Hypochlorite (Common examples include sodium hypochlorite (household bleach) and calcium hypochlorite (a component of bleaching powder, swimming pool chlorine) solutions may be required when there is continued transmission. Alcohol is less active, but there is no evidence that alcohol antiseptic handrubs are not effective for hand decontamination.</p> <p>R75</p> <p>R75 discharge return anticipated MDS dated [DATE], identified R75 had a mild cognitive impairment and had diagnoses that included traumatic head injury and chronic obstructive pulmonary disease (COPD). R75 was frequently incontinent of bladder and bowel. R75 required substantial to maximum assistance with toileting.</p> <p>R75's nursing progress note dated 3/21/25 at 4:59 p.m., identified R75 returned to the facility after a hospitalization . R75 was admitted to the hospital on 3/14/25 due to right lower lobe pneumonia and a complicated urinary tract infection (UTI). R75 tested positive for norovirus on 3/20/25 due to diarrhea. Contact precautions were initiated.</p> <p>R75's care plan revised 3/21/25, failed to identify R75's need for contact precautions.</p> <p>During an observation on 3/25/25 at 10:44 a.m., R75 was sitting in his wheelchair in his room. There was a contact precautions sign and PPE cart outside R75's room. Housekeeping (HK)-A entered R75's room with a hand-held basket with cleaning supplies. HK-A put on a pair of gloves but did not put on a mask or gown. HK-A cleaned R75's bathroom. High touch areas of R75's room and swept/mopped the floor.</p> <p>During an interview on 3/25/25 at 11:05 a.m., HK-A stated R75 was on contact precautions but that was only for cares, when staff had to touch R75.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 3/26/25 at 2:57 p.m., RN-A stated staff were educated that when a sign was on a resident's door and there was a PPE cart there, staff were expected to put on PPE. The facility even implemented reference cards for the staff name badge, so staff always had access to what was needed and when. When RN-A observed housekeeping not following precautions, RN-A educate them. RN-A stated housekeeping should have cleaned R75's room last and should have worn PPE while doing so.</p> <p>During an interview on 03/25/25 12:09 a.m., the DON stated housekeeping staff were expected to follow contact precautions while cleaning a room to prevent the potential transmission of infection.</p> <p>The facility policy Environmental Services - Cleaning dated 2020, identified the following:</p> <ol style="list-style-type: none"> 1. Standard cleaning procedures will be used in isolation rooms; however, isolation rooms will be cleaned last or the equipment and water changed before going into another room to clean. 2. Special attention will be paid to cleaning of environmental surfaces in the isolation room, as these surfaces are frequent sources of person-to-person transmission of infection. 3. If mop and bucket solution are contaminated with feces or bloody fluids, they will be changed. 4. Appropriate personal protective equipment (PPE) will be worn: <ul style="list-style-type: none"> a. Contact precautions <ul style="list-style-type: none"> - Gloves and gown will be worn when in the room - Must be removed with proper hand hygiene performed before leaving the room. 		