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	06/04/2026

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to protect residents' rights to be free from sexual abuse by failing to complete a comprehensive assessment for capacity to consent to sexual activity for 2 of 2 residents (R58, R61) with cognitive impairment who engaged in sexual activity. In addition, the facility failed to investigate unexplained bruising and vaginal bleeding for 1 of 1 resident (R58) in the context of known sexual activity. These failures resulted in an Immediate Jeopardy (IJ) as the facility did not determine whether either resident possessed the capacity to knowingly and voluntarily consent to sexual activity, creating a likelihood that one or both residents were subjected to non-consensual sexual contact and placing them at risk for serious harm, impairment, or injury. The immediate jeopardy began on [DATE] when the facility became aware of sexual activity between two residents with cognitive impairment and failed to immediately determine whether either resident possessed the capacity to consent or implement measures necessary to protect the residents from the likelihood of non-consensual sexual contact. Despite knowledge that sexual activity was occurring, the facility allowed continued unrestricted access between the residents and facilitated privacy for the relationship without first determining whether either resident possessed the capacity to consent to sexual activity. In addition, the facility failed to investigate unexplained bruising and vaginal bleeding in the context of known sexual activity, preventing the facility from determining whether the injuries were related to abuse, coercion, trauma, or other adverse outcomes associated with the relationship. Further, R58 and R61 had rooms next to each other farthest away from the nursing station, leaving more opportunity for sexual activity, that could have gone unnoticed by staff and was not documented. The administrator and director of nursing (DON) were notified of the IJ on [DATE], at 5:30 p.m. The IJ was removed on [DATE], at 7:00 p.m. when the facility successfully implemented a removal plan; however, noncompliance remained at the lower scope and severity level 2 [D] isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include:R58:R58's annual Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment and R58 wandered one to three days a week. R58 required supervision with dressing and moderate assistance with grooming and bathing. R58 was independent with transfers and ambulation. Diagnoses included Alzheimer's disease, neurocognitive disorder with Lewy bodies, dementia and anxiety. R58's Brief Interview and Staff Assessment for Mental Status (BIMS) identified the following:[DATE], R58 scored 11[represented moderate cognitive impairment]. R58 was able to immediately report three words she was asked to remember but could not recall one of the words without cueing and unable to recall the second word at all, after a few minutes. R58 was able to correctly identify the current year, the month, within five days and was unable to correctly identify what day it was. During the assessment, R58 asked about getting things done, needed a bust and a desire to drive and leave the facility. [DATE], identified R58 scored 5 [represented severe cognitive impairment]. R58 was able to immediately report three words she was asked to remember but was only able to recall one of the three words with cueing after a few minutes. R58 was unable to (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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	correctly identify the current day, month or yearXXX[DATE], identified R58 scored 11. R58 was able to immediately report three words she was asked to remember but could not recall the words without cueing after a few minutes. R58 was able to correctly identify the current day, month and year. R58 became tearful during the assessment and stated her spouse was divorcing her but could not recall her spouse's name when asked. When R58 was shown a picture of her 50th wedding anniversary, R58 was no longer tearful and correctly stated her spouse had passed away. The social services assessment documentation noted R58 had been having hallucinations and had a recent medication increase. R58's Care Area Assessment (CAA) summary for Cognitive Loss dated [DATE], identified R58 had a diagnosis of dementia and had poor vision. R58's cognition had declined due to natural progression and R58 had episodes of hallucinations. R58 was followed by psychiatry, and staff would continue to monitor. R58's CAA summary for Behavioral Symptoms dated [DATE], identified R58 had a diagnosis of dementia and would wander and walk laps in the unit. R58 was usually easily redirected. R58 had hallucinations and staff would continue to monitor. R58's care plan dated [DATE], identified R58 had cognitive loss due to dementia and became confused to her surroundings at times. R58 exhibited behavior symptoms of wandering, intrusive in others space, history of hallucinations or delusions. The care plan identified R58 had developed a relationship with a male peer a goal identified R58 was to have supportive monitoring to ensure all social or physical interactions were safe and appropriate. Staff were directed to monitor and document any changes in R58's sleep patterns which included wandering, restless, or unusual interactions with peers. Staff were to note any behavioral changes or signs of distress. Staff were to notify the social worker or director of nursing (DON) of any new or escalating concerns regarding the residents' interactions. Staff were to respect resident rights and provide privacy during interactions unless there were concerns about safety and updating family as appropriate. Further, R58 was a vulnerable adult and needed assistance to remain safe within the community. Approaches included observing and documenting changes in mood or behaviors that may increase R58's risk for abuse, implement interventions to minimize risk of harm to self and others if became violent or aggressive and to report, investigate any allegations or suspected abuse, neglect or exploitation.R58's progress notes [DATE] to [DATE], identified the following behavior and cognitive status concerns:On [DATE], R58 was wandering in and out of other resident's rooms looking for her baby. Resident was redirected and returned to her room each time.On [DATE], R58 appeared anxious at times and needed reassurance on what she needed to be doing at any given point. On [DATE], R58 wanted to talk with her physician about having another baby.On [DATE], R58 was noted to intermittently engage in conversation when no one else was present, while ambulating in the unit. R58 was also observed standing in the dining room and appeared to speak and gesture toward unseen stimuli. R58 started seeing dancers and their instruments. On [DATE], R58 requested water for her baby and gestured to a blanket rolled inside of her coat. An NA provided R58 with a sippy cup and R58 was observed pouring water from the cup into her hand and making motions toward the blanket. R58 showed no signs of distress and behaviors were consistent with R58's baseline. [DATE], R58 was concerned about the babies and showed staff the baby on her bed. R58 stated the baby looked just like the orphaned baby in the next room. On [DATE], R58 stated she and her husband were heading to the hospital to see her nephew. R58 was asked to come out to the common area and watch television. R58 stated she had to go pick up all the kids to take care of them. On [DATE], a nursing assistant (NA) reported R58 had walked up to the vitals machine and started taking notes on her paper and went looking for her children. R58 went to her room and fell asleep after 2:00 a.m.On [DATE], R58 was observed reaching for pictures hanging on the walls. R58 stated she was not sure how it was done, should she just take the pictures. R58 stated [NAME] told her to take the pictures but could not recall who [NAME] was and stated she would go back to her room and ask him. On [DATE], R58 was found kneeling on the floor by the exit door near her room. R58 was holding a winter jacket and stated she had to get on the floor so she could give her jacket to her daughter. R58 stated it was cold outside, and she did not want her daughter going outside without it. On [DATE], An NA reported R58 (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was very confused during bedtime cares. R58 kept reaching for something on the floor when there was nothing there. R58 was observed talking to the vitals machine, the bladder scanner and the mechanical lift. On [DATE], R58 was distraught over a project that she was left in charge of. R58 then discussed how to get the employees paid.On [DATE], R58 was pacing and stated she was worried people were coming to steal things. R58 was observed talking to herself as if talking with another person. R58 asked an NA if she could get into the dirty linen room to get the baby that was crying. On [DATE], R58 stated she thought her cross just died and asked staff to go to her room and look. Staff entered room and R58 lifted the blanket on her bed and stated well I guess it was not there. On [DATE], an NA reported R58 had come out of her room three to four times to look for her children.On [DATE], R58 was observed going into another resident's room and lying down on the bed. R58 was easily redirected. R58's progress notes [DATE] to [DATE], identified the following: On [DATE], R58 was found with a male resident (R61) in bed together. Both residents were not clothed and asked staff to leave them alone. Neither resident seemed uncomfortable or unhappy per the unidentified staff member who witnessed the incident. There were no signs of distress, coercion, or injury. The residents were provided with privacy. On [DATE], family member (FM)-D called and notified the facility the family wanted R58 to remain with her clothes on when in company of other residents and to sleep in her own bed every evening. After consultation with the director of nursing (DON), registered nurse (RN)-A notified the family that they understood the family's wishes, but the residents retained their right to autonomy and R58 could not be forced to comply with the family's request if it was against her wishes. The facility's plan was to continue to ensure R58's safety and dignity, while respecting her rights and preferences. On [DATE], scattered bruises were noted to both of R58's forearms in various stages of healing. R58 stated she occasionally bumped into things and bruised easily. On [DATE], an unidentified activity aide reported finding R58 in R61's bed. Both residents were undressed and in bed. When RN-A arrived at the resident's room, both residents were seated on the edge of the bed fully clothed. R58 was putting on her shoes, and when asked, agreed to return to her room. R58 was noted to be calm and cooperative with no signs of distress, however, was unsteady and complained she felt dizzy. Vital signs were obtained and were normal. FM-D was notified and requested to be called whenever those types of incidents occurred. On [DATE], an unidentified NA reported R58 had reported some bloody [vaginal]discharge. Staff checked toilet and room with no signs of blood. The NA assisted R58 with peri care and had not noted blood. On [DATE], bruising was noted on R58's right front anterior and inside of right thigh, both of which were the size of a nickel. On [DATE], licensed practical nurse (LPN)-A was notified by an unidentified housekeeper R58 was in bed with R61, both residents were not clothed. When LPN-A entered R61's room, both residents were standing in the R61's bathroom. R61 was just pulling up his pants and R58 was standing without pants on, and her brief was around her foot. LPN-A took R61 out of room to walk with him in the hallway and an unidentified nurse trainee assisted R58 to dress and then brought her out to the dining room. R58's medical record lacked evidence R58 was assessed following the first documented incident and subsequent incidents to determine her understanding and capacity to consent during each of the incidents. Further, the record lacked evidence R58 had been physically assessed following her reports of vaginal bleeding to the NA or if the bruises of unknown source had been investigated for potential cause of the injuries and if they were related to any of the sexual activity. R61:R61's quarterly MDS dated [DATE], identified R61 had severe cognitive impairment. No wandering, hallucinations, delusions, physical or verbal behaviors were documented. R61 was independent with all activities of daily living (ADLs) and was independent with transfer and ambulation. Diagnoses included Alzheimer's disease and dementia with psychotic disturbance, R61's BIMS assessments identified the following:[DATE], identified R61 scored 4 [represented severe cognitive impairment]. R61 was able to immediately report three words he was asked to remember but was only able to recall one of the words with cueing and unable to recall the other two words at all, after a few minutes. R61 was unable to correctly identify the current day, month or year, It was (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	noted that R61 was usually pleasant with other residents. [DATE], identified R61 scored 4. R61 was able to immediately report three words he was asked to remember but was unable to recall any of the words after a few minutes. R61 was able to correctly identify the current day, however, was unable to identify what the current month or year was, it was noted that R61 did not wander but had a history of exit seekingXXX[DATE], identified R61 scored 3 [represented severe cognitive impairment]. R61 was able to immediately report three words he was asked to remember but was unable to recall any of the words after a few minutes. R61 was unable to correctly identify the current day, month or year, It was noted R61 stated he knew what staff were asking him and denied pain or concern and stated he loved it at the facility. R61's CAA summary for Cognitive Loss dated [DATE], identified R61 had a diagnosis of dementia and Alzheimer's disease. R61s cognition had declined due to natural progression but did not appear distressed due to not remembering. R61 was no longer agitated when asked cognitive questions and staff would continue to monitor. R61's care plan dated [DATE], identified R61 had cognitive loss related to dementia. A goal was listed to receive services and assistance needed to his specific level of cognitive function. Staff were directed to help keep R61 orientated and provide him with reminders as needed. R61 had behaviors of a history of wandering and checking doors. Approaches included a mesh screen to his door to deter other wanderers from entering and that R61 enjoyed visiting with others and playing guitar. The care plan identified R61 had developed a relationship with a female peer with a goal identified as R61 would have supportive monitoring to ensure all social or physical interactions were safe and appropriate. Staff were directed to monitor and document resident interactions and observe for signs of distress coercion, confusion or changes in behavior related to interactions with female peer. Night staff were to monitor any changes in R61's sleep patterns which included wandering, restless, or unusual interactions with peers. Staff were to note any behavioral changes or signs of distress. Staff were to notify the social worker or director of nursing (DON) of any new or escalating concerns regarding the residents' interactions. Staff were to respect resident rights and provide privacy during interactions unless there were concerns about safety and updating family as appropriate. Further, R61 was a vulnerable adult and needed assistance to remain safe within the community. Approaches included observing and document changes in mood or behaviors that may increase R61's risk for abuse, implement interventions to minimize risk of harm to self and others if became violent or aggressive and to report, investigate any allegations or suspected abuse, neglect or exploitation.R61's progress notes from [DATE] to [DATE] identified the following for behavior and cognitive concerns:On [DATE]. R61 tried going into a female residents' room and stated he was going for a night cap. Staff redirected R61 four times, and he eventually went to a male's room to visit. On [DATE], R61 had several bug bites to his arms from standing outside. R61 refused to leave his shirt on when outside. On [DATE], R61 had flipped his mattress off the bed and stated he was looking for a part. NA reassured him his bed was put together correctly and did not have missing parts. R61 had a hard time communicating what he intended to say and often said he was looking for a part and then stated no that was not it while grabbing his head. On [DATE], R61 was given his medications and asked if he could get something to get him going. When asked what for, R61 replied, oh you know what for and winked. On [DATE], another resident kept telling R61 that supper was at 6:00 p.m. R61 became upset and told him to shut up and stated to staff if the resident did not shut up R61 was going to punch him. R61's progress notes from [DATE] to [DATE], identified the following: [DATE], R61 attempted to enter R58's room and stated he was going for a nightcap. Staff redirected R61 away from R58's room four times before R61 left to visit with another male resident. [DATE], R61 was found with another resident in his bed. Both residents were unclothed. R61 requested staff leave as soon as they entered the room. Both residents appeared to be enjoying each other's company. No signs of coercion or distress were noted. The residents' contact had been notified. [DATE], R61 brought an unidentified female resident to his room for a night cap. The female resident looked confused/worried, so staff redirected residents with no issues. [DATE], an unidentified aide reported R61 and R58 were in bed undressed. When RN-A (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	entered resident room, both residents were seated at the edge of the bed and fully clothed. R61 was observed putting on his shoes. R61 appeared calm and cooperative and displayed no signs of distress. R61 was alert and responsive and did not verbalize any discomfort or concerns. R61 stated he wished to remain in his room. Based on direct observations at the time of assessment, the interaction between R61 and R58 appeared consensual. R61's emergency contact was notifiedXXX[DATE], LPN-B was notified by an unidentified trained medication assistant (TMA) that R61 and R58 were in R58's room together. LPN-B checked on residents and redirected R61 back to his own room. Later, R61 was seen with R58 holding hands and touching her buttocks. After a few laps around the secured unit, the two residents entered R58's room. Staff were unable to redirect them. LPN-A was called to assist staff with redirection. [DATE], R61 entered female resident room and was attempting to get around the bed to reach the blinds. Staff reminded R61 they would help the female resident. R61 asked what was wrong with him helping her, R61 was redirected back to his room. [DATE], LPN-A was notified by an unidentified housekeeper R61 was in R58's room and both were lying in bed without clothing on. LPN-A entered R58's room and both residents were standing in the bathroom. R61 was just pulling up his pants and had t-shirt and socks on. R61 returned to his room with LPN-A and stated he was good. No concerns were noted. Another staff member stayed to help R58.R61's medical record lacked evidence that R58 was assessed following the first documented incident and subsequent incidents to determine his understanding and capacity to consent during each of the incidents. On [DATE], at 4:09 p.m. R58 was observed fully dressed, seated in a recliner in her room. R58's room was located on the secured unit furthest down the hall from the nurse's station. R61's room was located directly next to R58's room. Both rooms had a double panel of magnetic mosquito netting over the doorway on the outside of the doors. No other rooms on the secured unit had magnetic netting over their doorways. R58 stated she was unable to think of her neighbor's name or the name of the town in which she resided. R58 stated she had met a lot of people and did have friends here, but it was years ago. R58 was unable to form full sentences in response to any general questions. R58 stood up and walked out into the hallway. R58 pointed to R61's room and stated that it was her room. R58 stated she was going to go back to her room and ambulated a short distance away from her room before stopping and looking around. R58 turned back and ambulated to her own room and recliner. During interview on [DATE], at 8:16 a.m. housekeeper (HSK)-A stated she had entered R58's room on [DATE], saw that R61 was on top of R58 in bed and they were both naked. She saw that he was on top of her and did not really pay attention to her and just went out of the room to find help. She had been told that it had happened a lot, but that was the only time she had seen it. She reported it to the first nursing staff she found, which was LPN-A and LPN-A went to talk to the residents. When interviewed on [DATE], at 8:21 a.m. NA-B stated she knew R61 and R58 would go into either room, in the past the facility said that was ok. NA-B stated lately they had been told to separate them. NA-B had never witnessed any incidents. The two residents used to sit together in the dining room for meals but now they separated them to different tables. NA-B was unsure why it changed or when it changed and why they were separated in the dining room for meals. When interviewed on [DATE], at 8:29 a.m. NA-C stated he had heard of the incidents that had occurred but had never witnessed any. NA-C stated they had just been told they would go into each other's rooms occasionally and to redirect them if possible and let the nurse know. During interview on [DATE], at 8:30 p.m. LPN-C stated she was aware there had been some inappropriate behaviors and was told to just keep an eye on both. Typically staff just tried to keep the two residents apart or to make sure they were not alone. R61 was good about knowing where his room was. R58 usually knew where her room was but there had been times when she would ask where her room was and have to be directed. When interviewed on [DATE], at 10:11 a.m. RN-A stated R58 and R61 had interactions in the past, but they were sporadic in nature. RN-A did not know who found the two residents together on [DATE] as she had only talked to the nurse that had been notified. LPN-A was the nurse that had been first notified of the incident and did the follow up. The plan going forward was the same as the other (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	incident, however she was not sure if any specific assessment had been completed. The DON was not aware of any type of assessment that could be used for a situation such as that. The facility had monitored the residents to make sure they were not uncomfortable with the situation. In the past, R58 had an altercation with another female resident on the secured unit and had been very verbal that she did not like that resident and would tell staff she did not want that resident in her room. The DON stated she felt R58 would react the same way with R61 if she was uncomfortable with the incidents. The interdisciplinary team (IDT) discussed the interactions each time they occurred and how the residents were at the time, prior and after each incident. Staff were able to document there were no signs of discomfort or fear. It was the DON's understanding that if the resident was able to demonstrate they did or did not want something to happen the facility would honor that. The DON did not have any documentation that staff had conversations with R58 that she denied feeling coerced and that she knew R61 was not her spouse. The DON was not aware that the resident primary physicians and psychiatric providers had not been notified of the incidents when they occurred, she would have expected the RN to have notified them both. The DON had not been aware of R58 bruises that were documented on [DATE] and [DATE]. The DON was not aware that bloody vaginal discharge had been reported, and she would have expected R58 would have been assessed and physician notification as bloody vaginal discharge would not be normal for a resident of R58's age. During telephone interview on [DATE], at 12:50 p.m. FM-A stated she had been told by the facility R58 had an interest in a male resident who also resided on the secure unit. FM-A had told the facility that she wanted R58 to be safe. FM-A was concerned with issues regarding balance, transferring in and out of bed and falls as well as spending time alone in a male resident's room as safety issues. FM-A initially told the facility that she did not want R58 to have any interactions with the male resident but had been told it was R58's right and R58 was able to make those decisions on her own. The staff were doing their best and trying to navigate the situation as best as they could, but FM-A was uncomfortable with it. FM-A stated R58 was able to communicate if she was hurting or if something did not feel good, but she was not sure if R58 had the ability to give consent. There are times FM-A would get phone calls and ask if R58 should take the flu shot and FM-A gave permission for that. Prior to having Alzheimer's, incidents of that nature would have been very upsetting to R58, and FM-A did share that information with the facility staff. FM-A did not know if R58 had the capacity to say if she wanted or did not want the gentleman to enter her bed. Nighttime could be a confusing time for R58. R61 was a nice, friendly man and FM-A knew they were friends. FM-A did not think R58 mistook him for her spouse. During interview on [DATE], at 2:30 p.m. RN-A stated she had been told the residents had the right to consent and follow up was only needed if injury was noted. Both residents had dementia and their capacity to consent may be on different levels. If the residents were able to verbalize or demonstrate no, get away from them, then they were able to process in their head whether they want to give consent or not. R58 and R61 were able to tell her if they do not want to do something or want to refuse the attention. R58 could not sign for medical treatments. The facility called on family to consent to any medical treatment or appointments and did not ask R58 for their consent. Some days R58 was more aware and verbal with the staff and usually was pretty good at communicating. The staff judged is she was consenting by the way she communicated with them and how she responded to the situation. RN-A stated the reported vaginal bleeding had never been confirmed to have happened, it had only been reported by R58, and staff had not actually saw any bleeding. RN-A stated it depended on the day if R61 was able to give consent to sexual activity. RN-A stated she had been following direction and was told that both residents had the ability to consent. The last time RN-A spoke with R61's contact person, he was not overly keen on the idea but understood and basically told the staff to do what they could do. RN-A did not remember if there had been any discussion about moving the resident rooms further apart. During interview on [DATE], at 3:40 p.m. social worker (SW)-A stated R58 and R61 were becoming friends. Staff had reported there were no signs of distress or crying when any of the incidents occurred. The facility knew they were (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Vincent	516 Walsh Street Crookston, MN 56716

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	consensual actions by the residents' actions. The residents sought each other out, not just any female or male. There was an incident SW-A had witnessed when another male resident, not R61, had touched R58's shoulder and she clearly said no to him and moved away

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to honor a resident's right to make choices regarding daily activities by implementing a blanket requirement that residents be accompanied by staff when accessing a secured outdoor courtyard, without an individualized assessment of the resident's safety, abilities, or need for supervision. This affected 1 of 2 residents reviewed for resident rights (R42), who expressed a desire to independently access the courtyard as part of his customary routine.Findings include: R42's admission MDS dated [DATE], identified R42 and intact cognition and was independent with most ADLs and transfers. R42 was unable to ambulate and independently used a wheelchair for mobility. R42 had not exhibited any physical, verbal behaviors toward others and no wandering had occurred during the observation period. R42 had not exhibited any hallucinations, delusions, however, did have documented rejection of care. Diagnoses included paranoid schizophrenia, dementia, congestive heart failure, above the knee amputation, delusional disorders, generalized anxiety and post-traumatic stress disorder. R42's care plan revised 4/17/26, identified R42 was a pleasant man who was able to make his needs known. R42 was private and preferred his independent activities versus group programs. R42's interests included model cars, watching movies, music and going outside. Staff were directed to offer and escort R42 outdoors for programs or pleasure as weather allowed. R42's customary routine was identified that he enjoyed watching movies, working on his model cars, older music and smaller groups, but may not be able to stay if feeling anxious. R42 also enjoyed being outside. R42 had impaired mobility related to a right above the knee amputation, however, R42 was independent with transfer and activities of daily living (ADLs).On 6/1/26, at 12:32, R42 was observed seated in his wheelchair in his room. R42 was alert and able to move his wheelchair around his room and in the hallway independently. R42 stated he was not happy because he had always been able to go outside to the locked unit's fenced and secure courtyard whenever he liked to and now, he had been told he would not be able to go outside unless he was accompanied by a staff member. R42 stated it was because another resident had fallen out in the courtyard a few weeks ago and had been injured, but that resident should never have been allowed out there on her own in the first place. R42 stated he liked to go outside in the mornings when the weather was cooler and there was less wind but staff was not available to take him outside because they were busy with other resident cares. When the staff did take him outside, it was afternoon and hotter and he liked to sit out there alone, not with a group of people. R42 stated he had complained to the unit nurse, activities, social worker and administration but they just told him it was the rule for the unit. On 6/3/26, at 1:33 p.m. R42 was observed seated in the outside courtyard, in his wheelchair, visiting with R61. An unidentified staff member was seated nearby. The outside courtyard had a cement walkway and patio and a gazebo as well as grassy areas. The courtyard was fenced with a high fence and the gate was locked. R42 was listening to music on his phone and R61 was playing along on his guitar. The unidentified staff member stood up and notified the two residents she had other things to do, and the residents needed to return inside the facility. The two residents were observed complaining and stated they wanted to stay outside and why did they have to go in but they eventually went inside the facility with continued verbal complaints. R42 returned to his room. When interviewed on 6/2/26, at 10:38 a.m. registered nurse (RN)-A stated residents were never really allowed to go to the outside courtyard without supervision, but staff only recently started to reinforce the rule, when a resident recently fell in the outer courtyard. The outside courtyard was a closed fenced area with a locked gate. The door to the outside area was locked and could only be accessed by a staff members badge or family could take a resident outside. There had been some conversation regarding if more cognitive intact residents could be assessed to go out on their own, but she had been told that staff should be with the residents at all times. So far, no residents had been assessed (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to see if they could safely go out to the secured courtyard independently. Another problem was the door to come inside was locked and so the resident would not have access back into the building. During interview on 6/4/26, at 9:10 a.m. the social worker (SW)-A stated she was struggling with the issue as well. There was no call system since the facility had changed how the door operated. She had questioned if there was some type of call, they could give the resident to use outside or if the resident could just use their cell phone to call. The facility used to have a different door that they could lock but a resident outside could still get in. SW-A had brought up R42's complaint to the interdisciplinary team (IDT) and they were working on it, attempting to figure out a way more cognitively intact residents could go outside without supervision. The other problem was there was no shade. The facility had thought of putting an umbrella up but there was a concern it could blow over in the wind. On 6/4/26, at 1:44 p.m. a joint interview was conducted with the administrator and the director of nursing (DON). The DON stated the facility recently updated their locks to make the building more secure. The facility had also identified a concern with the current staff practices of allowing residents to out into the secured courtyard unsupervised. The ground was uneven and an accident risk, so the facility implemented that staff needed to be out with the residents in that area to ensure safety. It had always been that way, and staff had just gotten lax on the rule. They had not had a chance to evaluate each resident to see if they could be deemed safe to go out to the courtyard. One resident had recently fallen into the courtyard and because of that fall, it was discovered that staff were allowing resident's go to outside alone. If R42 were to wheel out there and go off the sidewalk, there was a risk he could tip his chair. The facility did not have therapy or nursing to assess how safe residents were when they were outside. The facility policy Resident Rights and Notification of Resident Rights, last reviewed 8/28/25, identified the facility acted to protect and ensure the rights of residents. Social services or designee would inform the residents of the Resident Rights at the time of admission and with changes to regulatory statute. Any time state or federal laws relating to resident rights or facility rules changed during the residents' stay, the residents would be promptly informed of the changes. The policy listed 45 resident rights which included exercise of rights, planning and implementing care, accommodation of needs, and grievances.The facility policy Chemical and Physical Restraints last reviewed 8/31/23, identified medical symptoms that warrant the use of restraints would be documented in the resident's medical record. Before a restraint was used the IDT would determine the presence of a medical symptom that required a restraint and how the restraint would treat the medical symptom, protect the resident's safety and assist the resident in attaining or maintaining their highest practicable level of physical and psychological wee-being. Alternative to the restraint and the risk benefits would be discussed with the residents. For the residents to be fully informed, the IDT would explain the context of the resident's condition and circumstances, and the potential risks and benefits of options under consideration. Alternatives would be considered and discussed with the resident or resident representative.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to support a resident's expressed choice regarding smoking for 1 of 1 resident (R17) reviewed for resident choices. The facility failed to assess R17's request to smoke, evaluate options to accommodate the preference, and involve the interdisciplinary team after R17 repeatedly expressed a desire to resume smoking. Findings include:R17's quarterly Minimum Data Set, dated [DATE], identified R17 had moderate cognition and was able to make her needs known. R17's diagnoses included dementia, anxiety, depression and diabetes.R17's smoking risk assessment dated [DATE], identified R17 had a history of smoking but did not plan on smoking during the stay at the facility.R17's care plan printed on 4/25/26, failed to address R17's smoking preference.R17's progress notes identified the following:On 5/5/26 at 8:56 a.m., R17 reported to licensed social worker (LSW)-A she wanted to go outside and have a cigarette. On 5/18/26 at 9:07 a.m., R17 reported to LSW-A she missed smoking and wished she could still smoke.The facility failed to provide evidence of assessing R17 for ability to smoke safely off campus, since R17 expressed an interest in smoking.R17's care conference note dated 5/7/26 failed to identify discussions regarding R17's desire to smoke.On 6/2/26 at 10:30 a.m. R17 attended a resident council meeting held by the state agency (SA). R17 stated she wanted to smoke although she was told by staff that she couldn't.During interview on 6/2/26 at 11:12 a.m., R17 stated she had smoked for over 50 years prior to admission, was forced to quit smoking to be admitted to the nursing home and was not given the option to go off-site to smoke.During interview on 6/4/26 at 10:14 a.m., LSW-A stated all new residents were informed they could not smoke because the facility was a smoke-free campus and only two residents were grandfathered in and allowed to smoke. LSW-A stated R17 requested the desire to smoke on two occasions; however, LSW-A stated she had not documented follow up discussions with the interdisciplinary (IDT) team and the IDT team did not evaluate options to accommodate R17's preference.On 6/4/26 12:57 p.m., registered nurse (RN)-A stated residents with a history of smoking were assessed on admission by nursing and social services. The nursing assessment included questions regarding the resident's smoking history, whether they planned to smoke while a resident at the facility, and if they were provided information regarding being a non-smoking facility. RN-A stated she was aware that R17 wanted to smoke although had not completed a smoking assessment since admission.The facility maintained a blanket practice prohibiting smoking by new residents and failed to conduct the individualized assessment and consideration of options required by its own policy after R17 repeatedly expressed a desire to smoke.The undated facility Non-Smoking - Tobacco Free/Smoke Free Campus policy identified residents that wished to smoke were to sign in/out of the facility and leave the property to smoke. Upon admission, residents would be evaluated/assessed for safe smoking practices and ability to smoke independently if they chose to do so when they were off campus. Based on the assessment, the residents may be provided with equipment to aid in safety (such as a smoking apron) when they chose to smoke while off campus. The assessment further identified the facility would consult with the resident and/or the resident representative for alternate assistance to use off campus smoking options.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to monitor and reevaluate the continued need for a wander guard utilized as a means to restrict the resident from accessing the outdoors for 1 of 1 resident (R17) reviewed for restraints. The facility failed to complete a reassessment despite changes in R17's behaviors and expressed desire to independently access the outdoors, resulting in the continued use of the intervention without documentation supporting ongoing need. Findings include:R17's quarterly Minimum Data Set, dated [DATE], identified R17 had moderate cognition, and was independent with activities of daily living. R17's diagnoses included dementia, anxiety, depression and diabetes. The assessment identified R17 used a wander/elopement alarm daily.R17's restraint/adaptive equipment assessment dated [DATE], identified R17 received antidepressants, antipsychotics, anxiolytics and narcotics, and recently experienced a decline in condition, although the type of decline was not included on the assessment. The assessment identified no other alternatives had been attempted prior to initiating the wander guard [device to alert staff to exiting secured areas of the building) and the wander guard was to be always utilized during all activities. The questions regarding whether the device met the definition of a physical restraint were not answered in the assessment.On 6/1/26 at 1:43 p.m., R17 was observed wearing a wander guard bracelet on her left wrist. R17 stated when she arrived at the facility staff had placed a wander guard on her wrist. R17 stated she was able to go outside although when she walked through the doors an alarm sounded, and staff came to check on her. R17 stated she did not like wearing the wander guard and wanted it removed. R17 stated the wander guard prevented her from enjoying the outdoors. Further, R17 stated she was told if she didn't go outside without a staff member eventually, she could have the wander guard removed. During interview on 6/3/26 at 4:05 p.m., nursing assistant (NA)-A stated if a resident had a wander guard and went out the doors an alarm sounded notifying staff, a resident had exited the doors. NA-A stated that when R17 first arrived around the beginning of the year, she had tried to go outdoors unattended but had not tried recently.During interview on 6/4/26, at 10:14 a.m., licensed social worker (LSW)-A stated wander guard assessments were completed on admission, quarterly, annually and with significant changes. The interdisciplinary (IDT) team met daily, Monday through Friday, and discussed residents who had wandering/elopement behaviors, the residents' safety concerns, and whether the wander guard should be continued. If the team determined a resident was at risk, social services completed an elopement risk assessment and nursing determined if a wander guard was appropriate. LSW-A stated R17 had an assessment completed on 1/22/26, however, was unable to find documentation that reassessments had been completed. LSW-A stated R17 should have been reassessed within three months of the initial assessment to determine if the wander guard was still needed.During interview on 6/4/26 at 1:23 p.m., LSW-B stated R17 had not shown a desire to leave the facility, and an elopement reassessment should have been completed at the quarterly mark, around April 2026.During interview on 6/4/26 at 1:44 p.m., the DON stated the facility policy identified that elopement risk assessments were to be completed on admission, quarterly, annually, with significant changes and as needed on an urgent basis. When a resident had elopement and/or wandering behaviors, the nurses were instructed to enter a progress note identifying the behaviors, interventions and outcomes. The DON stated residents with wander guards were encouraged to notify staff when they wanted to go outside because the alarm sounded when a resident passed a specific point and staff could turn the alarm off quickly. The DON stated R17 had an elopement risk assessment completed on admission and should have been reassessed quarterly to determine if the wander guard was still needed.The undated Elopement Alarm System policy identified the elopement alarm system is utilized to enhance safety for residents who wander or risk elopement from the facility. It is the facility policy to monitor the (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	devices used for proper placement and for proper functioning of the door system as well as the resident signaling device. All residents determined at risk by the IDT team for wandering off units or with the potential for elopement from the facility will wear a signaling device. Assessment and consent will be completed on implementation and reviewed quarterly and with any significant change for continued need.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to report allegations and suspicions of resident-to-resident sexual abuse to the State Agency for 2 of 2 residents (R58 and R61) reviewed for abuse after becoming aware that the residents, who had significant cognitive impairment, were engaging in sexual activity without a determination of their capacity to consent. The facility also failed to report potential injuries of unknown source for 1 of 2 residents (R58) who exhibited unexplained bruising and vaginal bleeding.Findings include: R58's annual Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment and wandered one to three days a week. R58 required supervision with dressing and moderate assistance with grooming and bathing. R58 was independent with transfers and ambulation. Diagnoses included Alzheimer's disease, neurocognitive disorder with Lewy bodies, heart disease, anxiety, and dementia. R61's quarterly MDS dated [DATE], identified R61 had severe cognitive impairment. No wandering, hallucinations, delusions, physical or verbal behaviors were documented. R61 was independent with all activities of daily living (ADLs) and was independent with transfer and ambulation. Diagnoses included Alzheimer's disease, dementia with psychotic disturbance, and atrial fibrillation (irregular heartbeat). R58's care plan with review date 5/20/26, identified R58 had cognitive loss due to dementia and became confused to her surroundings at times. R58 exhibited behavior symptoms of wandering, intrusive in others space, history of hallucinations or delusions. The care plan identified R58 had developed a relationship with a male peer a goal identified R58 was to have supportive monitoring to ensure all social or physical interactions were safe and appropriate. Staff were directed to monitor and document any changes in R58's sleep patterns which included wandering, restless, or unusual interactions with peers. Staff were to note any behavioral changes or signs of distress. Staff were to notify the social worker or director of nursing (DON) of any new or escalating concerns regarding the resident's interactions. Staff were to respect resident rights and provide privacy during interactions unless there were concerns about safety and update family as appropriate. Further, R58 was a vulnerable adult and needed assistance to remain safe within the community. Approaches included to observe and document changes in mood or behaviors that may increase R58's risk for abuse, implement interventions to minimize risk of harm to self and others if became violent or aggressive and to report, investigate any allegations or suspected abuse, neglect or exploitation.R58's medical record lacked an assessment identifying the resident had the capacity to consent to a sexual relationship.R61's care plan with review date 5/20/26, identified R61 had cognitive loss related to dementia. A goal was listed to receive services and assistance needed to his specific level of cognitive function. Staff were directed to help keep R61 orientated and provide him with reminders as needed. R61 had behaviors of a history of wandering and checking doors. Approaches included a mesh screen to his door to deter other wanderers from entering and that R61 enjoyed visiting with others and playing guitar. The care plan identified R61 had developed a relationship with a female peer with a goal identfied as R61 would have supportive monitoring to ensure all social or physical interactions were safe and appropriate. Staff were directed to monitor and document resident interactions and observe for signs of distress coercion, confusion or changes in behavior related to interactions with female peer. Night staff were to monitor for any changes in R61's sleep patterns which included wandering, restless, or unusual interactions with peers. Staff were to note any behavioral changes or signs of distress. Staff were to notify the social worker or director of nursing (DON) of any new or escalating concerns regarding the resident's interactions. Staff were to respect resident rights and provide privacy during interactions unless there were concerns about safety and update family as appropriate. Further, R61 was a vulnerable adult and needed assistance to remain safe within the community. Approaches included to observe and document changes in mood or behaviors that may increase R61's risk for abuse, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	implement interventions to minimize risk of harm to self and others if became violent or aggressive and to report, investigate any allegations or suspected abuse, neglect or exploitation.R61's medical record lacked an assessment identifying the resident had the capacity to consent to a sexual relationship.R58's progress notes 10/1/25 to 6/2/26, identified the following: 10/3/25, R58 was found with a male resident (R61) in bed together. Both residents were not clothed and asked staff to leave them alone. The residents were provided privacy. 10/9/25, scattered bruises were noted to both of R58's forearms in various stages of healing. R58 stated she occasionally bumped into things and bruised easily. 11/19/25, an unidentified activity aide reported finding R58 in R61's bed. Both residents were undressed and in bed. 12/11/25, an unidentified nursing assistant (NA) reported R58 had reported some bloody discharge. Staff checked toilet and room with no signs of blood. The NA assisted R58 with peri care and had not noted blood. There was no further documentation. 3/5/26, bruising was noted on R58's right front anterior and inside of right thigh, both of which were the size of a nickel. 5/7/26, licensed practical nurse (LPN)-A was notified by an unidentified housekeeper R58 was in bed with R61, both residents were not clothed. R61's progress notes 9/20/25 to 6/2/26, identified the following: 10/3/25, R61 was found with another resident in his bed. Both residents were unclothed. 11/19/25, an unidentified aide reported R61 and R58 were in bed undressed. 5/7/26, LPN-A was notified by an unidentified housekeeper R61 was in R58's room and both were lying in bed without clothing on. During interview on 6/2/26, at 11:01 a.m. LPN-A stated she had documented the incident in each of the resident's medical records and reported the incident to the unit manager RN-A. She did not fill out an event report, just documented in the resident progress notes because she had been told the family were aware of the incidents and were ok with them. When interviewed on 6/2/26, at 2:30 p.m. registered nurse (RN)-A stated regarding the first documented incident on 10/3/25, RN-A stated she had done an assessment of R58's overall status, such as if any harm. Regarding filing a Vulnerable Adult (VA) report, she would have to look at the policy, but her understanding was if there were incidents of coercion, or concerns with safety, such as physical harm, slapping, biting hitting, she would elevate the concerns to the director of nursing (DON) or the administrator. She had been told in these incidences, was that the resident's had a right to consent and follow up would only be needed if there were injury. RN-A had never filed a VA report herself but had discussed the incidents with the team for guidance. RN-A stated with bruises of unknown origin, staff were to notify the physician and fill out an event report. RN-A had documented R58's bruised forearms on 10/9/25. R58 had stated she bumped into things, RN-A took her word for it, but thought now she should have followed up more on it. It was not assessed in relation to the sexual relationship.During interview on 6/2/25, at 11:57 a.m., the DON stated the facility had not reported the intimate incidents that had occurred between R58 and R61 because, when discussed with the facility interdisciplinary team (IDT), it was felt the incidents were consensual in nature and not abuse. The DON stated she was not aware of the bruises on R58's forearms, documented 10/9/25. It was the facility's process that bruises of unknown origin were reported to the state agency. When bruises of unknown injury were reported an incident report was filled and a vulnerable adult (VA) report was completed. When interviewed on 6/2/25, at 3:40 p.m. the social worker (SW)-A stated the incidents between the residents were not reportable as the resident's had a right to intimacy. As far as R58's bruises, R58 was unsteady and bumped into things. The bruises would be for nursing to evaluate. SW-A stated she was not involved in VA reports any longer. She used to be but now submission of VA reports fell to nursing and the DON, as they were the ones completing the investigations. Bruises would need to be reported if there were no explanation for them or no other way they could have occurred other than abuse. SW-A did not get notified of incidents and/or injuries any longer. Those sorts of reports went to the DON. SW-A was more involved in the financial side of things and if any nursing issues, would go to the DON. It was usually determined by the DON or unit manager if an incident needed follow up or further investigation. During joint interview with the administrator, corporate RN (CP)-F and the DON on 6/2/26, at 5:00 p.m., the DON stated based on the resident's mood and behaviors, it was felt the (continued on next page)

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	245484	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa St Vincent	516 Walsh Street Crookston, MN 56716

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incidents were consensual and not abuse and so the facility decided not to report the incidents to the state agency (SA). R58's bruises had never been reported because she walked around holding on to her arms, bumped into things and was on aspirin, so the facility staff came to the conclusion that was the cause. The facility's policy was to report bruises of unknown origin, fill out an incident report and complete a VA report. The DON was not sure if she had been notified of the bruises found on R58's inner thigh.The facility policy Abuse Prevention Plan with review date 7/21/22, identified the facility would develop an individual abuse prevention plan for each vulnerable adult who received services in the facility. The plan would include the resident's susceptibility to abuse, risk of abusing other vulnerable adults and specific measures to be taken to minimize the risk of abuse. Resident incident reports and medical records would be routinely monitored for indicators of possible abuse. Any allegations involving abuse would be investigated whether they caused injury or harm or no injury or harm. Staff would notify the facility administrator, DON and director of social services. If the event involved abuse or resulted in serious bodily injury, staff were required to report to the SA immediately, but no later than two hours after forming the suspicion. If the event did not involve abuse and did not result in bodily injury, staff were required to report to the SA no later than 24 hours after forming the suspicion.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to investigate potential resident-to-resident sexual abuse for 2 of 2 residents (R58, R61) reviewed for abuse. The facility became aware of repeated sexual activity between two residents with significant cognitive impairment but failed to assess either resident's capacity to consent to sexual activity. As a result, the facility was unable to determine whether the encounters were consensual and failed to complete a thorough abuse investigation. Additionally, the facility failed to investigate bruising and reports of vaginal bleeding experienced by R58 in relation to the known sexual activity. Findings include:R58R58's annual Minimum Data Set (MDS) dated [DATE] identified severe cognitive impairment. Diagnoses included Alzheimer's disease, neurocognitive disorder with Lewy bodies, and dementia.R58's care plan identified cognitive loss related to dementia, confusion, wandering, hallucinations or delusions, and identified R58 as a vulnerable adult. Staff were directed to report and investigate any allegations or suspected abuse, neglect, or exploitation.R58's progress notes identified the following:On 10/3/25, R58 and R61 were found together in bed unclothed and requested privacy.On 11/19/25, staff again found R58 and R61 undressed in bed together.On 5/7/26, staff found R58 and R61 in bed together without clothing.The record failed to contain evidence the facility assessed either resident's capacity to consent to sexual activity following any of the incidents.The record further identified:On 10/9/25, scattered bruises in various stages of healing were noted on both forearms.On 12/11/25, R58 reported bloody vaginal discharge.On 3/5/26, bruising was noted to the right anterior thigh and inner thigh.The record failed to contain evidence the facility investigated whether the bruising or report of vaginal bleeding were related to the known sexual activity involving R58 and R61.R61R61's quarterly MDS dated [DATE] identified severe cognitive impairment. Diagnoses included Alzheimer's disease and dementia with psychotic disturbance.R61's care plan identified cognitive loss related to dementia and identified R61 as a vulnerable adult. Staff were directed to observe for signs of distress, coercion, confusion, or behavioral changes related to interactions with R58 and to report and investigate any allegations or suspected abuse, neglect, or exploitation.R61's progress notes identified staff found R58 and R61 unclothed together on 10/3/25, 11/19/25, and 5/7/26.The record failed to contain evidence the facility assessed R61's capacity to consent to sexual activity or completed an abuse investigation to determine whether the encounters were consensual.On 6/2/26 at 10:11 a.m., registered nurse (RN)-A stated she did not know if any investigation or assessments had been completed following the incidents involving R58 and R61. RN-A stated she had not documented assessments related to the incidents or the bruising identified on R58.On 6/2/26 at 11:01 a.m., licensed practical nurse (LPN)-A stated she documented the 5/7/26 incident but did not complete assessments/investigations on either resident and was unsure whether any assessments/investigations had been completed by others.On 6/2/26 at 11:57 a.m., the director of nursing (DON) stated no assessments had been conducted following the incidents to evaluate physical injury or assess the residents' judgment or capacity to consent. The DON stated the facility believed the encounters were consensual based on the residents' behaviors and no further investigation had been conducted and the facility staff knew the incidents were consensual by how the residents behaved and their actions and no further investigation had been conducted. The DON further stated the facility did not complete a formal investigation process. At 5:00 p.m., the DON stated the facility did not conduct a formal investigation because staff believed the incidents were consensual. The DON further stated R58's bruising had not been investigated, and she was unaware of the reports of inner thigh bruising and vaginal bleeding.The facility's Abuse Prevention Plan directed staff to investigate allegations involving abuse and to monitor incident reports and medical records for indicators of possible abuse

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to provide education regarding the benefits and potential side effects of pneumococcal vaccination and failed to document that education was provided prior to obtaining a vaccination decision from the resident representative for 1 of 5 residents (R42) reviewed for immunizations. Findings included:R42's Comprehensive Minimum Data Set (MDS) dated [DATE], identified R42 as [AGE] years old, had mild cognitive impairment and diagnoses that included heart failure, peripheral vascular disease, diabetes, and dementia. R42 was offered the pneumococcal vaccination but declined.R42's Immunization Report dated 3/23/26, identified R42 received pneumovax (PPSV23) on 5/20/09, and a pneumococcal conjugate vaccine (Prevnar 13) on 5/20/09. R42's Immunization Report dated 8/30/23, identified R42 received pneumovax (type unknown) on 4/28/14, and a pneumococcal conjugate vaccine (Prevnar 13) on 9/8/16. R42's medical record did not include evidence R42 or R42's representative received education regarding pneumococcal vaccine booster and there was no indication R42 was offered the pneumococcal vaccine per CDC guidance.R42's Immunization Consent form dated 3/23/26, identified R42's son declined the pneumococcal vaccination by phone. However, the form did not include evidence R42 or R42's representative received education regarding pneumococcal vaccine booster per CDC guidance.During an interview on 6/3/26 at 10:24 a.m., RN-B stated R42's family declined the pneumococcal vaccination by phone. Most family members didn't want to read the education, so RN-B didn't mail any education to anyone for review, nor did she document that.During an interview on 6/4/26 at 8:50 a.m., the director of nursing (DON) stated the resident and the resident representative need to be provided with all the education regarding vaccinations to ensure they understand what they are refusing or consenting to. Documentation should reflect their understanding of that education.The facility policy Pneumococcal Vaccines for Residents dated 1/9/25, identified the facility would provide education and administration of the PPSV23 and PCV13 to the residents according to CDC recommendations. CDC now recommended pneumococcal conjugate vaccine (PCV15 or PCV20) for adults who never received a prior pneumococcal conjugate vaccine (PCV13) if they are 50 years or older and have certain chronic medical conditions or other risk factors. For adults who have only received PCV13 but not PPSV23, CDC recommends vaccine providers give PPSV23 as previously recommended. The infection preventionist or designee will provide the resident and/or the responsible party

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure eligible residents received COVID-19 vaccination after consent was obtained for 1 of 5 residents (R30); and the facility failed to provide current Centers for Disease Control and Prevention (CDC) COVID-19 vaccine education regarding the potential benefits and risks of vaccination to resident representatives prior to obtaining a refusal for 2 of 5 residents (R16, R42) reviewed for COVID-19 vaccination status. These failures resulted in one resident not receiving a consented-to vaccination and had the potential to affect residents' ability to make informed vaccination decisions. Findings include:Unadministered VaccinesR30R30's admission Minimum Data Set (MDS) dated [DATE], identified R98 as [AGE] years old, cognitively aware and had diagnoses that included Multiple Sclerosis, congestive heart failure (CHF), Rheumatoid Arthritis, and Parkinson's disease. R30 was not up to date for COVID-19 vaccination. The MDS did not identify if R30 was offered a COVID-19 vaccination.R30's Immunization Consent form dated 2/17/26, identified R30 consented to receive the COVID-19 vaccination.R30's medical record failed to identify R30 had received the corresponding COVID-19 vaccination.During an interview on 6/3/26 at 10:21 a.m., registered nurse (RN)-B stated she was responsible for the facility's infection prevention program and the resident vaccinations. RN-B stated she was unsure why R30 had not received the COVID-19 vaccination as R30 had consented. RN-B stated the facility did not currently have any COVID-19 vaccine, however, RN-B stated when she ordered the vaccine the facility would have the COVID-19 vaccine available. RN-B usually ordered vaccines once per year in the fall. R30 consented to receive the COVID-19 vaccine on 2/17/26. Review of the medical record through 6/4/26 failed to identify the vaccine had been administered or documentation explaining why it was not administered despite approximately three, and one-half months having elapsed since consent was obtained.EducationR16R16's admission MDS dated [DATE], identified R16 as [AGE] years old, had a mild cognitive impairment and diagnoses that included CHF and atrial fibrillation (irregular heartbeat). R16 was not up to date for COVID-19 vaccination. The MDS did not identify if R16 was offered a COVID-19 vaccination.R16's Immunization Consent form dated 3/23/26, identified R16's son declined the COVID-19 vaccination by phone. However, the form failed to identify the education provided to R16's son.R42R42's admission MDS dated [DATE], identified R42 as [AGE] years old, had a mild cognitive impairment and diagnoses that included heart failure, peripheral vascular disease, diabetes, and dementia. R42 was not up to date for COVID-19 vaccination. The MDS failed to identify if R42 was offered a COVID-19 vaccination.R42's Immunization Consent form dated 3/23/26, identified R42's son declined the COVID-19 vaccination by phone. However, the form failed to identify the education provided to R42's son.During an interview on 6/3/26 at 10:24 a.m., RN-B stated R16 and R42's family declined the COVID-19 by phone. Most family members didn't want to read the education, so RN-B doesn't mail any education to anyone for review, nor does she document that.During an interview on 6/4/26 at 8:50 a.m., the director of nursing (DON) stated there was no documentation in R30's medical record that reflected R30 was given the COVID-19 vaccination nor why R30 had not received it. The DON stated should have received the vaccination as R30 had consented to. The DON also stated the resident and the resident representative need to be provided with all the education regarding vaccinations to ensure they understand what they are refusing or consenting to. Documentation should reflect their understanding of that education.The facility policy COVID-19 Vaccine and Booster for Residents dated 5/11/21, identified the facility would assure all residents that are eligible are offered the COVID-19 vaccination and booster doses when available.