DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6YSD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00444

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245588**
2. STATE VENDOR OR MEDICAID NO. (L2) **887342900**
3. NAME AND ADDRESS OF FACILITY
   (L3) **ST WILLIAMS LIVING CENTER**
   (L4) **212 WEST SOO STREET, BOX 30**
   (L5) **PARKERS PRAIRIE, MN** (L6) **56361**
4. TYPE OF ACTION: 7 (L8)
   1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **10/30/2018** (L34)
7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
   01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA
8. ACCREDITATION STATUS: __ (L10)
   0 Unaccredited, 1 TJC, 2 AOA, 3 Other

FISCAL YEAR ENDING DATE: (L35) **06/30**

11. .LTC PERIOD OF CERTIFICATION
    From (a) :
    To (b) :
10. THE FACILITY IS CERTIFIED AS:
    A. In Compliance With Program Requirements Compliance Based On:
       ___ 1. Acceptable POC
    B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

12. Total Facility Beds **53** (L18)
13. Total Certified Beds **53** (L17)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	53			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
    Christina Martinson, HFE - NE II 10/15/2018 (L19)
18. STATE SURVEY AGENCY APPROVAL Date:
    Joanne Simon, Enforcement Specialist 10/15/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
    _X_ 1. Facility is Eligible to Participate
    ____ 2. Facility is not Eligible
    (L21)
20. COMPLIANCE WITH CIVIL RIGHTS ACT:
21. 1. Statement of Financial Solvency (HCFA-2572)
    2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
    3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **12/01/1991** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)
25. LTC EXTENSION DATE: (L27)
26. TERMINATION ACTION: (L30)
    VOLUNTARY 00
    01-Merger, Closure
    02-Dissatisfaction W/ Reimbursement
    03-Risk of Involuntary Termination
    04-Other Reason for Withdrawal
    INVOLUNTARY
    05-Fail to Meet Health/Safety
    06-Fail to Meet Agreement
    OTHER
    07-Provider Status Change
    00-Active
27. ALTERNATIVE SANCTIONS
    A. Suspension of Admissions: (L44)
    B. Rescind Suspension Date: (L45)
28. TERMINATION DATE: (L28)
29. INTERMEDIARY/CARRIER NO. **03001** (L31)
30. REMARKS
31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered November 15, 2018

CMS Certification Number (CCN): 245588

Administrator
St Williams Living Center
212 West Soo Street, Box 30
Parkers Prairie, MN 56361

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective October 2, 2018 the above facility is certified for::

53 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 53 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
November 15, 2018

Administrator
St Williams Living Center
212 West Soo Street, Box 30
Parkers Prairie, MN 56361

RE: Project Number S5588029

Dear Administrator:

On September 17, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 30, 2018. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On October 30, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 1, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 30, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 2, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 30, 2018, effective October 2, 2018 and therefore remedies outlined in our letter to you dated September 17, 2018, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 6YSD
Facility ID: 00444

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2. STATE VENDOR OR MEDICAID NO. (L2) **887342900**

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(L3) **ST WILLIAMS LIVING CENTER**
(L4) **212 WEST SOO STREET, BOX 30**
(L5) **PARKERS PRAIRIE, MN** (L6) **56361**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **08/30/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **06/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12. Total Facility Beds **53** (L18)

13. Total Certified Beds **53** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___ 1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	53			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date:
Christina Martinson, HFE - NE II — 09/28/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Joanne Simon, Enforcement Specialist — 10/15/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
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23. LTC AGREEMENT BEGINNING DATE (L41)

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25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
September 17, 2018

Administrator
St. Williams Living Center
212 West Soo Street, Box 30
Parkers Prairie, MN 56361

RE: Project Number S5588029

Dear Administrator:

On August 30, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 9, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions

are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by November 30, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human

Services that your provider agreement be terminated by March 1, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245588	A. BUILDING ______ B. WING ______	08/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST WILLIAMS LIVING CENTER	212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 8/27/18, through 8/30/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 8/27/18, through 8/30/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in	F 582		10/2/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 09/26/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245588	A. BUILDING ______ B. WING ______	08/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST WILLIAMS LIVING CENTER	212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 1 nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due	F 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245588	A. BUILDING ______ B. WING ______	08/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST WILLIAMS LIVING CENTER	212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 2 the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to provide the required notice of Medicare non-coverage (NOMNC) (CMS 10123), notice upon discontinuation of Medicare part-A services for 2 of 2 residents (R22 and R61) who's Medicare part A coverage ended and continued to remain in the facility. In addition, the facility failed to provide the required skilled nursing facility advanced beneficiary notice of non-coverage (SNF ABN) (CMS 10055), notice of Medicare part A non-coverage for 1 of 2 residents (R61) who's Medicare part A coverage ended and remained in the facility. Findings include: R22's Center for Medicare and Medicaid Service (CMS)-10055 signed as received on 7/6/18, identified a last covered day (LCD) of 7/10/18, when R22's Medicare part A coverage would end. R22's SNF Determination on Continued Stay form dated 7/6/18, revealed R22's Medicare part A coverage would end on 7/10/18, and R22 would remain in the facility. The form revealed R22's family member had signed the generic notice of non-coverage on 7/6/18. However, R22's medical record lacked the required CMS-10123 notice. R61's SNF Determination on Continued Stay	F 582	*Audit was completed on all nursing home residents who have had Medicare part A services end in the month of September 2018. Per audit the facility did provide the required notices (NOMNC) (CMS 10123) and (SNF ABN) (CMS 10055) to all residents. *Facility's Denial Binder has been updated with Instructions for ABN's and Denials along with blank sample forms and examples for completing the forms. This is for the RN's to reference to assure compliance. All other forms have been removed to prevent wrong forms being used. *Medical Director will be updated on final procedure/policy by Oct 2, 2018 All RN's who are responsible for filling out Denials and ABN's will be educated on new procedure by Oct 1, 2018 *RN Manager to complete a MDS 3.0 Weekly Audit form which will include all Denials and ABN's to assure compliance weekly. Results will be discussed at QA committee meetings quarterly to assure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245588	A. BUILDING ______ B. WING ______	08/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST WILLIAMS LIVING CENTER	**212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361**

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F 582	Continued From page 3 form dated 7/16/18, revealed R61's Medicare coverage would end on 7/17/18, due to refusal of therapy. The form revealed R61 had signed the generic notice of non-coverage on 7/16/18. However, R61's medical record lacked the required CMS 10123 notice. R61's medical record lacked an advanced beneficiary notice of non-coverage, CMS-10055 notice, informing R61 of her estimated daily cost for services. On 8/27/18, at 4:04 p.m. Registered nurse manager (RNM)-A confirmed R22, and R61 had not received the required notice of provider non-coverage (CMS 10123) notice upon their Medicare part A coverage ending. RNM-A stated R22 had received skilled therapy services, returned to his baseline and had remained in the facility. She indicated R61 had received skilled therapy services and had refused therapy on three consecutive days. RNM-A stated R61 had not received the required SNF ABN notice, CMS 10055 notice upon discharge from therapy. She indicated R61 had remained in the facility. On 8/27/18, at 4:51 p.m. the director of nursing (DON) stated she would have expected R22 and R61 to have received the required notice of provider non-coverage, CMS 10123. She indicated she would have expected R61 to have received the required SNF ABN form CMS 10055 notice. The DON stated the residents had been provided an older, generic, facility form and should have used the required CMS notices. A facility policy titled, St Williams Living Center written representation for MDS assessment, reviewed 5/2018, identified denial forms would be	F 582		

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F 582	Continued From page 4 given and explained to residents and/or representatives and signed per CMS/Medicare advantage regulation.	F 582		
F 607 SS=C	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an abuse policy that included all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported to the Administrator, State Agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within the required time frames. This deficient practice had the potential to affect all 50 residents residing in the facility. Findings include: Review of the facility's abuse policy titled Vulnerable Adult Act/Abuse Prevention Plan revised 1/31/17, was completed on 8/29/18. The	F 607	F607 The facility will act to protect residents found to have been affected and residents in similar situations and the facility will ensure that the problem does not recur by implementing the following: - The Vulnerable Adult Act/Abuse Prevention Plan Policy was reviewed and updated under Internal Reporting Section with the following: All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately. If the events that cause allegation involve abuse or result in	10/8/18

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F 607	Continued From page 5	F 607		

policy included the following;

-Any person with knowledge or suspicion of suspected violations shall report immediately.

-After reviewing the incident the director of nursing/nurse manager shall then determine whether it is maltreatment and must be reported. This decision must be based on whether or not an error by a care given (giver) resulted in injury or harm which reasonably required the care of a physician. When the incident does result in injury or harm which reasonably requires the care of a physician, it MUST be reported as possible maltreatment to OHFC (Office of Health Facility Complaints).

-Thefts and/or Misappropriation of Resident Property-all incidents will be reported to and investigated by social services. The results of the investigation will be made to the administrator by social services.

-Bruises or abrasions of unknown source: identified the administrator would be notified immediately and a Vulnerable Adult Report would be sent to OHFC.

-All suspected cases or allegations of mistreatment, abuse, neglect or misappropriation of resident property would be reported to the administrator immediately. The administrator, along with the director of nursing, or in their absence the charge nurse, would determine action and reporting to outside agencies. When an alleged or suspected case of mistreatment, neglect, injuries of an unknown source, or abuse was reported the facility (nursing and/or social services) would notify the following person or

serious bodily injury, the alleged violation will be reported immediately, but not later than 2 hours after the allegation is made. If the events that cause the allegation do not involve abuse and do not result in serious bodily injury, the violations will be reported immediately, but not later than 24 hours. All alleged violations will be reported immediately to the administrator AND to other officials including the State Agency and adult protective services where state law provides for jurisdiction in the LTC facility.

The facility designee (Nursing and/or Social Services) will notify the following persons or agencies:
- Administrator
- Initial report to OHFC/MDH per website
- Resident's family or representative
- The attending physician
- The one exception in which you must call MAARC (844-880-1574) is when the incident requires immediate emergency services to protect the individual.

Initial reporting of allegations: If an incident or allegation is considered reportable, the Administrator or designee will make an initial (immediate but not later than 24 hours) report to the State Agency. A follow up investigation will be submitted to the State Agency within five (5) working days.

Serious Bodily Injury Reporting – Immediately but not later than 2 Hours: If the events that cause the reasonable

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F 607	Continued From page 6 agencies which included: initial report to OHFC/MDH (Minnesota Department of Health) per website or one exception in which you must call MAARC (844-880-1574) was when the incident required immediate emergency services to protect the individual. An additional facility policy was provided by the director of nursing titled Reporting Reasonable Suspicion of a Crime revised 4/19/17. The policy identified the suspicion of a crime must be reported no later than two hours after forming the "reasonable suspicion" of the crime if the victim suffered serious bodily injury. If there was no serious bodily injury, the suspicion of a crime must be reported within 24 hours of forming the "reasonable suspicion". The crime must be reported to the police and the state survey agency. The policies failed to include all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the the State Survey Agency . On 08/30/18, at 9:42 a.m. director of nursing (DON) confirmed the facility's abuse policy titled Vulnerable Adult Act/Abuse Prevention Plan revised 1/31/17, was the most current policy. She confirmed the policy had been updated with the policy for suspicion of a crime, however, she indicated she was not aware the policy needed to	F 607	suspicion result in serious bodily injury to a resident, the covered individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion; All Other Reporting – Immediately but not later than 24 Hours: If the events that cause the reasonable suspicion do not result in serious bodily injury to a resident, the covered individual shall report the suspicion immediately, but not later than 24 hours after forming the suspicion. - Training will be completed for all staff and volunteers regarding the updated Vulnerable Adult Act/Abuse Prevention Plan Policy by October 8, 2018. Annual training about the Vulnerable Adult Act/Abuse Prevention Plan Policy is provided for all staff and volunteers. - The Medical Director will be educated on the final updated policy on Oct 2, 2018 - The facility plans to monitor its performance to make sure that solutions are sustained by completing Quarterly audits on all allegations to ensure that they were reported to follow the policy. The results of the audit will be reviewed at the QA meeting and policy reviewed annually.	

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	245588	A. BUILDING ______ B. WING ______	08/30/2018

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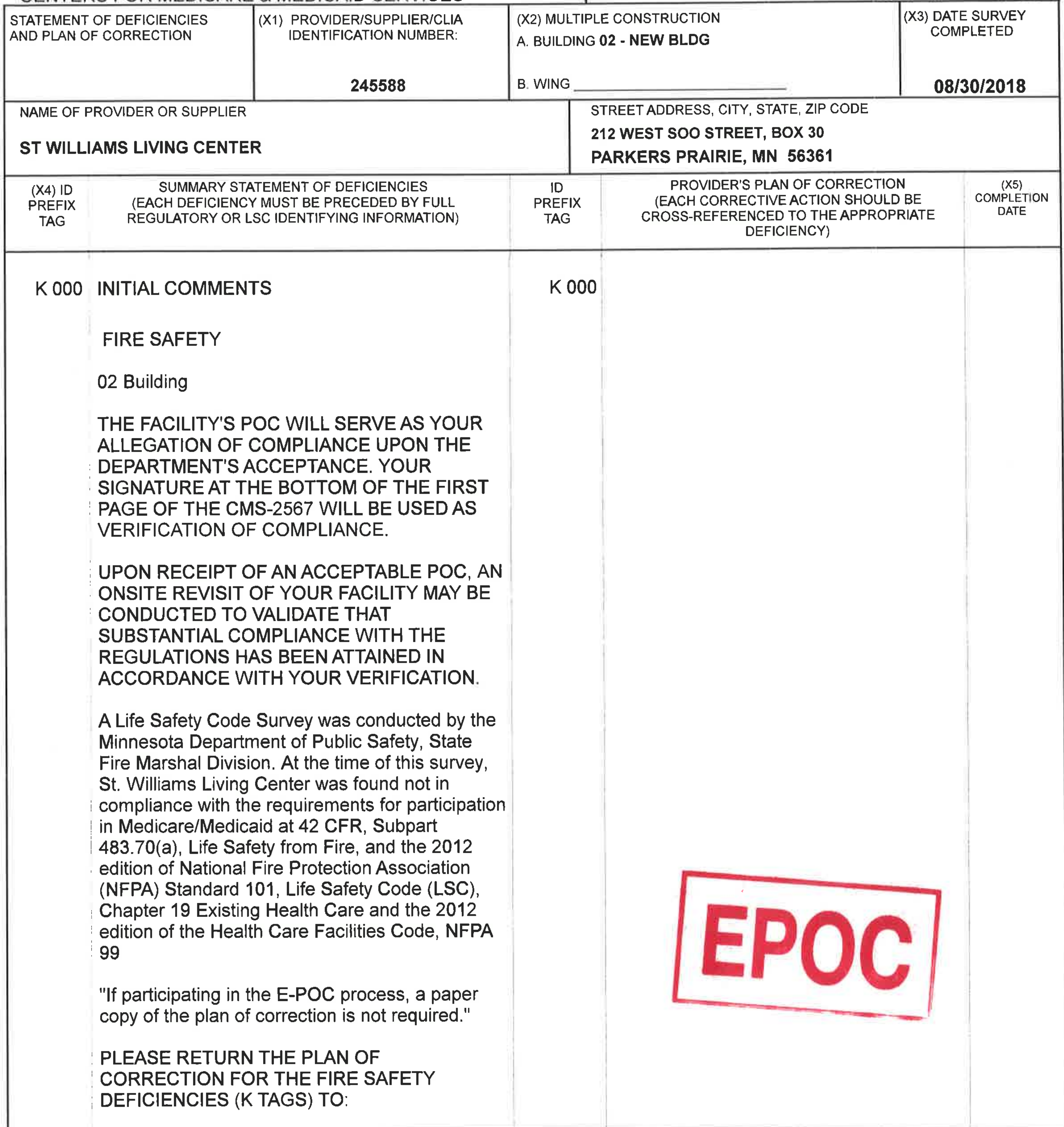
F 607	Continued From page 7 include the timelines for reporting all the various allegations of abuse and neglect.	F 607		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5588026

PRINTED: 09/25/2018
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245588	A. BUILDING 02 - NEW BLDG B. WING	08/30/2018

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K 000	INITIAL COMMENTS FIRE SAFETY 02 Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. Williams Living Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Health Care Facilities Code, NFPA 99 "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 09/21/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245588	A. BUILDING **02 - NEW BLDG** B. WING	**08/30/2018**

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ST WILLIAMS LIVING CENTER	**212 WEST SOO STREET, BOX 30** **PARKERS PRAIRIE, MN 56361**

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K 000	Continued From page 1	K 000		

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101

Or by email to:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

The facility was inspected as two separate buildings:

St. Williams Living Center is a 1-story building with no basement. The building was constructed at 6 different times. The original building was constructed in 1963 and was determined to be type II(000) construction. In 1967 an addition was added to the south that was determined to be of Type II(111) construction. In 1976 an addition was added to the west that was determined to be of Type II(111) construction. In 1996 additions were added to the northwest that was determined

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	245588	A. BUILDING **02 - NEW BLDG** B. WING ____	**08/30/2018**

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K 000	Continued From page 2 to be of Type V(111) construction. In 2001 an addition was added to the northeast that was determined to be of Type V(111) construction. In 2007 an addition was added to the southeast that was determined to be of Type II(111) Construction. The building is fully fire sprinklered throughout. The facility has a fire alarm system that includes smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 53 beds and had a census of 50 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 131 SS=D	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.	K 131		8/30/18

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	245588	A. BUILDING 02 - NEW BLDG B. WING	08/30/2018

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K 131	Continued From page 3 Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This **REQUIREMENT** is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the proper 2 hour fire resistive ratings for occupancies as described in the Life Safety Code (NFPA 101) 2012 edition section 19.1.3.3. This deficient practice could allow for the transfer of smoke or fire from another occupancy and an undetermined amount of residents, staff and visitors. Findings include: On the facility tour between 8:00 am to 11:00 am on 08/30/2018 observations revealed the 2 hour fire barrier at the chapel/McConnell Court intersection has an insulated pipe penetration that is not properly fire stopped around the annular space. This deficient condition was confirmed by the facility Administrator and the Director of Maintenance.	K 131	Fire stop was installed at the insulated pipe penetration by the 2 hour fire barrier at the chapel/McConnell Court intersection. This correction took place on 8/30/2018. The maintenance team corrected the problem and the administrator, Tim Kelly, verified that the problem was corrected.	

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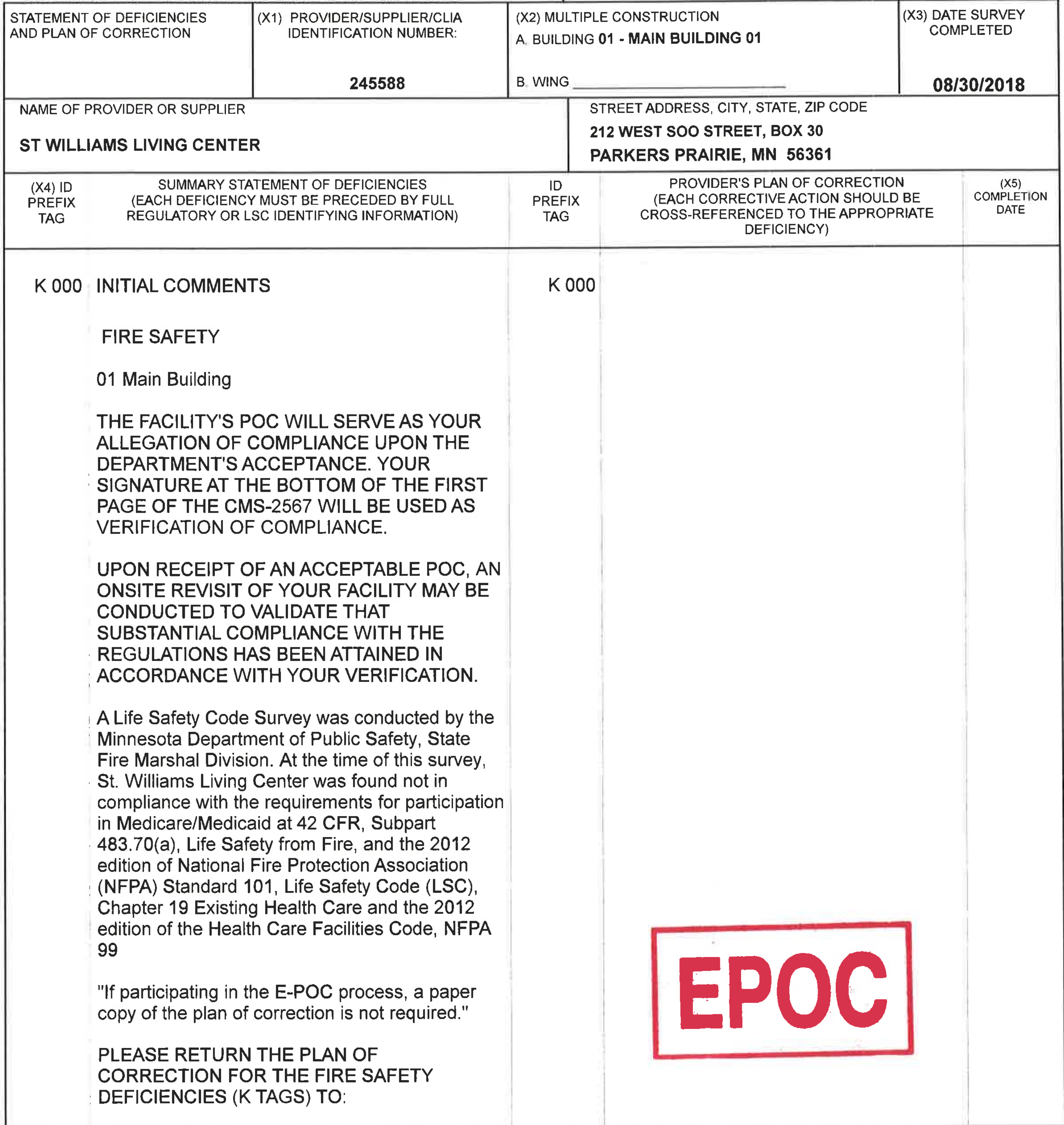

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	245588	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/30/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. Williams Living Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Health Care Facilities Code, NFPA 99 "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/21/2018

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	245588	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/30/2018

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K 000	Continued From page 1	K 000		

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101

Or by email to:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

The facility was inspected as two separate buildings:

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST WILLIAMS LIVING CENTER	**212 WEST SOO STREET, BOX 30** **PARKERS PRAIRIE, MN 56361**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 to be of Type V(111) construction. In 2001 an addition was added to the northeast that was determined to be of Type V(111) construction. In 2007 an addition was added to the southeast that was determined to be of Type II(111) Construction. The building is fully fire sprinklered throughout. The facility has a fire alarm system that includes smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 53 beds and had a census of 50 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is **NOT MET.**	K 000		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K 321		8/30/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245588	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/30/2018**

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K 321	Continued From page 3 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility to maintain a hazardous storage room in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect the quick and efficient exiting for 11 of the 53 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 11:00 am on 08/30/2018 observations revealed the door on soiled utility room 115 did not positively latch. This deficient condition was confirmed by the facility Administrator and the Director of Maintenance.	K 321	The door closer for soiled utility room 115 was adjusted so that the door completely closes on its own. This correction took place on 8/30/2018. The maintenance team corrected the problem and the administrator, Tim Kelly, verified that the problem was corrected.	
K 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in	K 341		8/30/18

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	245588	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/30/2018**

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K 341	Continued From page 4 accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (2012) section 19.3.4.1, 9.6.1.3 and NFPA 72 National Fire Alarm Code (2010) section 17.7.4.1. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect an undetermined amount of residents staff and visitors. Findings include: On the facility tour between 8:00 am to 11:00 am on 08/30/2018 observations revealed that the smoke detector in Nourishment room 104 was within 36 inches of an HVAC diffuser. This deficient condition was confirmed by the facility Administrator and the Director of Maintenance.	K 341	The smoke detector in nourishment room 104 was moved so that it is more than 36 inches of the HVAC diffuser. This correction took place on 8/30/2018. The maintenance team corrected the problem and the administrator, Tim Kelly, verified that the problem was corrected.	

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K 521	Continued From page 5	K 521		
K 521 SS=B	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain proper bathroom exhaust as required by the 2012 Life Safety Code (NFPA 101) section 9.2.2 and NFPA 91 Standard for Exhaust Systems for Air Conveying of Vapors, Gases, Mists and Noncombustible Particulate Solids. This deficient practice could negatively affect 3 of the 53 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 11:00 am on 08/30/2018 observations revealed the bath fans in resident rooms, 109, 209, and 328 were not operable. This deficient condition was confirmed by the facility Administrator and the Director of Maintenance.	K 521	The air flow for the exhaust fan in room 109 was increased. A circuit breaker was tripped for the exhaust fan in room 209. The circuit breaker was reset and the fan was inspected and found to be working properly for room 209. The motor of the fan serving room 328 had been found to be burnt out, so the fan was replaced. The corrections for the bath fans in rooms 109, 209, and 328 took place on 8/30/2018. The maintenance team corrected the problem and the administrator, Tim Kelly, verified that the problem was corrected.	8/30/18