Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 20, 2024

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

RE: CCN: 245588
Cycle Start Date: December 11, 2024

Dear Administrator:

On December 11, 2024, a 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 March 11, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by June 11, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

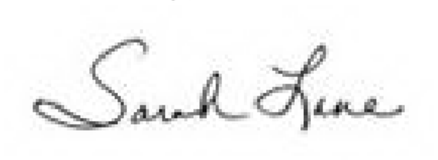
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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 _____	C 12/11/2024

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 On 12/9/24 to 12/11/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 12/9/24 to 12/11//24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaint was reviewed: The following complaint was reviewed with no deficiencies issued. H55881373C (MN00101497). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/30/2024

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.

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F 000	Continued From page 1 validate that substantial compliance with the regulations has been attained.	F 000		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, food was not served in a sanitary manner for 15 residents who dined in the north dining area, observed during dining services. In addition, the facility failed to maintain the ice machine in a sanitary manner to prevent potential illness for 15 residents who currently received ice from the ice machine in the north dining area. Further, the facility failed to maintain proper holding food temperatures for 13 of 17 residents observed to receive egg salad sandwiches. These deficient practices had the potential to cause foodborne	F 812	Food Handling How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Staff were immediately retrained on proper gloves usage and appropriate utensil usage to eliminate the potential of touching ready to eat foods. The Dietary Manager spoke with all staff at the start of their next shift on safe handling of ready	1/9/25

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F 812	Continued From page 2 illness. Findings include: FOOD SERVICE During an observation on 12/10/24 at 12:06 p.m., dietary aide (DA)-A washed her hands in the north kitchen, applied gloves to both hands, picked up an i-pad with resident dietary information on it and placed it on the counter next to the steam trays. DA-A opened a drawer with her left hand, removed utensils from the drawer with both hands and placed utensils into each food item on the steam tray area. DA-A proceeded to open a bag of buns, touched the i-pad with her left hand, picked up a baked potato with her right hand and placed the potato onto a plate. DA-A opened the potato with both hands and a knife and placed other food items on the plate with utensils and handed the plate to the server. DA-A touched the i-pad with her left hand, picked up a bun with her left hand and placed onto the plate. DA-A picked up a baked potato with her right hand, placed onto the plate, opened the potato with both hands and a knife, then placed other food items on the plate with utensils and handed the plate to the server. DA-A continued to touch the i-pad in between each resident served, picked up a bun and or a baked potato with her gloved hands for all residents who received a bun and or baked potato. DA-A then opened a kitchen cupboard with the same gloved hand, removed a salt shaker and handed it to the server. DA-A continued to touch the i-pad in between each resident's meal setup, placed a bun and or baked potato onto residents plates for the remaining of the lunch meal wearing the same pair of gloves. At no time during the	F 812	to eat foods when using gloves and utensils. The Dietary staff will be competencied for proper glove and utensil usage on January 9th, 2025 during a dietary meeting conducted by the dietary manager. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents in the facility could have potentially been affected by the deficient practice because dietary staff work with all residents in the facility. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Staff were immediately retrained on proper glove usage and appropriate utensil usage to eliminate the potential of touching ready to eat foods. The Dietary Manager spoke with all staff at the start of their next shift on safe handling of ready to eat foods when using gloves and utensils. The Dietary staff will be competencied for proper glove and utensil usage on January 9th, 2025 during a dietary meeting conducted by the dietary manager. During the meeting all staff will be retrained on the importance of proper glove and utensil usage to prevent cross-contamination and eliminate the risk of potential harmful bacteria. How the facility will monitor its corrective actions to ensure that the deficient	

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F 812	Continued From page 3 observation did DA-A wash hands and re-apply new gloves. During an interview on 12/10/24 at 1:40 p.m., DA-A confirmed she touched the i-pad frequently throughout the meal service, touched the cupboard/drawer and then touched the buns and baked potatoes while wearing the same pair of gloves and without washing her hands. DA-A stated the i-pad was to be cleaned after each shift with an alcohol wipe and the i-pad had not been cleaned prior to meal service. DA-A stated other staff used the i-pad during the day to assist residents with deciding their meals for each day. DA-A stated the cupboards and drawers were not on a schedule to be cleaned. DA-A stated staff should not touch food with gloved hands if the gloves have touched other objects as germs could get onto the residents food. During an interview on 12/10/24 at 1:55 p.m., dietary manager (DM) verified the expectation of staff would be to wash hands and change gloves when the staff touched non-food items. DM confirmed it was important to prevent the spread of germs to the residents and could cause food-borne illness. ICE MACHINE During an observation of the north kitchen area on 12/10/24 at 11:27 a.m., the ice and water machine spouts on the ice machine had a white powder substance approximately one fourth to one half an inch in height around the entire inside and outside of both spouts. In addition, there was a white powder substance present expanding across the entire drain plate below the ice and water spouts.	F 812	practice is being corrected and will not recur. Supervisory rounds have been increased by the dietary manager from random observations to a minimum of once per shift worked per employee per week for the first 30 days to observe food handling practices and ensure compliance with glove use requirements then decreasing to once per month observations for next 60 days, providing feedback and correction as needed to staff members who are not using gloves appropriately. The dietary manager will conduct ongoing staff education on hand hygiene, glove use, food safety cross-contamination into regular staff meetings. The results will be reviewed at the February and May 2025 QAPI meeting. Identify who is responsible for the corrective actions and monitoring of compliance. The dietary manager is responsible for the corrective action and monitoring of compliance. The date that each deficiency will be corrected. January 9th, 2025 Food Temperatures How corrective action will be accomplished for those residents found to have been affected by the deficient	

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F 812	Continued From page 4 During an interview on 12/10/24 at 1:55 p.m., DM confirmed a white powder substance was present on the ice and water spouts of the ice machine. DM stated the facility had issues with the ice machine leaking. DM stated there was no cleaning process in place for the ice machine. DM stated the white powder substance had the potential to spread germs to the residents. During an interview on 12/11/24 at 8:56 a.m., maintenance staff stated the ice machine dripped when the ice melted and the machine was cleaned every three months. Maintenance staff stated the facility did not keep a log to verify cleaning of the ice machine. Maintenance staff stated the white powder substance could have bacteria present and residents could develop illness as a result. FOOD TEMPERATURE During an observation on 12/9/24 at 4:45 p.m., DA-B entered the north kitchen with a cart of food from the main kitchen. DA-B placed hot food items on the steam trays and proceeded to obtain beverages and fruit cups from the fridge and delivered to each resident table. DA-B placed a plastic tray with six egg salad sandwiches from the cart on the counter next to the steam tray and placed a small bowl of egg salad on the counter next to the sandwiches. During continued observation at 5:12 p.m., DA-B temped the egg salad in the bowl at 50 degrees. DA-B temped an egg salad sandwich at 55.7 degrees. DA-B started to place an egg salad sandwich onto a resident place when surveyor intervened and asked DA-B what the recommended temperature for cold food would be. DA-B looked at the facility	F 812	practice. The egg salad was immediately removed by cook from serving after temperature was found to be above 41 degrees. Staff were immediately retrained on proper holding foods temperatures. The Dietary Manager spoke with all staff at the start of their next shift on safe food temperatures and how to keep cold foods under 41 degrees Fahrenheit. A policy (Handling Cold Foods for Tray Line Policy) was developed that all cold items be placed on ice during serving to keep food temperatures under the appropriate temperatures. On January 9th 2025, during a dietary meeting conducted by the dietary manager all dietary staff will be reeducated on proper food holding temperatures. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents in the facility could have potentially been affected by the deficient practice because dietary staff work with all residents in the facility. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. During state survey the egg salad sandwiches were sitting next to the hot steam table. When these were temped, they were above 41 degrees. Staff were reeducated on not placing cold food next	

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F 812	Continued From page 5 food temp log to see what the recommended cold food holding temperature should be. DA-B then placed the egg salad bowl and sandwiches in the freezer. During an observation on 12/9/24 at 5:19 p.m., three and a half egg salad sandwiches were on the center counter on a plastic tray in the main kitchen. The cook temped the egg salad sandwich at 51.6 degrees. During an interview on 12/9/24 at 5:44 p.m., the cook stated the egg salad sandwiches were removed from the walk in fridge prior to food service and placed onto the center counter. The cook stated cold sandwiches were usually placed on a plastic tray and served from the center counter. The cook verified cold sandwiches were not put on ice. The cook stated cold food items holding temperature should be under 41 degrees to prevent residents from becoming ill. During an interview on 12/10/24 at 9:22 a.m., DM confirmed the expectation staff were to temp foods prior to serving and if a cold food was not in the recommended holding temperature, staff would place the food back in the fridge and re-temp prior to serving. DM stated the process was important to prevent foodborne illness. During an interview on 12/11/24 at 10:26 a.m., dietician confirmed the expectation staff would be to have cold foods on an ice-bath during food service. Dietician verified it was important to maintain holding temperatures, to prevent foodborne illness and bacteria growth, and to ensure quality of food for the residents. The Food and Drug Administration food code	F 812	to hot steam tables. When serving cold food, the food will stay in the refrigerator as long as possible then placed on ice furthest away from steam table during serving to ensure temperatures stay below 41 degrees Fahrenheit. Temperatures will be taken before, during and after serving to ensure food is maintained at the correct temperature. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The dietary manager will complete an audit on temperatures taken once per shift worked per employee, per week for the first 30 days to ensure that the deficient practice is correct and is not reoccurring and providing immediate correction and education if temperatures are not in the correct range. This will be decreased to once per month observations for the next 60 days. The results will be reviewed at the February and May 2025 QAPI meeting. Identify who is responsible for the corrective actions and monitoring of compliance. The dietary manager is responsible for the corrective action and monitoring of compliance. The date that each deficiency will be corrected.	

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F 812	Continued From page 6 identified the danger zone refers to the range of temperatures at which bacteria can grow between 40 degrees Fahrenheit (F) and 140 degrees F. For food safety, keep food below or above the "danger zone." A facility policy titled Food Safety Requirements dated 1/25/23, food service safety referred to handling, preparing, and storing food in ways that prevented foodborne illness. Staff would monitor food temperatures while holding for delivery to ensure proper hot and cold holding temperatures were maintained. Staff would refer to the current Food and Drug Administration (FDA) food code and facility policy for food temperatures. Foods and beverages would be distributed and served to residents in a manner to prevent contamination and maintain food at the proper temperature and out of the Danger Zone. Staff would not touch food with bare hands, exhibiting appropriate use of gloves. Gloves would be worn when directly touching ready-to-eat foods. A facility policy titled Sanitization of I-Pad Screen dated 10/3/23, identified staff were to clean the screen, sides, and back of the I-pad with an alcohol wipe before and after each meal and let air dry. A facility policy titled Ice Chests and Machines undated, identified the facility was to keep the ice machine clean and sanitary to prevent contamination. The ice machine would be drained, cleaned and sanitized according to manufacturer's specification. The tray would be run through a dishwasher or sterilized daily. A manufacturer form provided by the facility titled Scotsman Ice Systems dated September 2020,	F 812	12/12/2024 and will be reviewed again on January 9th, 2025 Ice Machine During an observation of the north kitchen area on 12/10/24 at 11:27 a.m., the ice and water machine spouts on the ice machine had a white powder substance approximately one fourth to one half an inch in height around the entire inside and outside of both spouts. In addition, there was a white powder substance present How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The ice machine was taken out of service until 12/30/2024 when a descaling chemical was used to remove the scale buildup. The ice machine was not being cleaned on a regular basis and will now be cleaned daily. The manufacturer guideline recommends minimum time between internal cleanings at 6 months. The maintenance staff will complete inside cleaning every 6 months with the next cleaning completed within six months from December 30, 2024. The dietary manager will educate staff on correct ice machine cleaning practices on January 9th, 2025 during a scheduled dietary meeting. How the facility will identify other residents having the potential to be affected by the same deficient practice.	

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F 812	Continued From page 7 identified over time the drip tray and cup rest/spouts may become coated with scale or dirt. They could be removed and scrubbed in a sink. The spouts/chutes and drip tray were to be washed and to use ice machine scale remover if needed to dissolve scale. Recommended cleaning the ice machine every six months and more frequent cleanings may be required based on the mineral content of the water, run time and potential airborne contamination.	F 812	All residents may receive ice from this ice machine in the facility and could have potentially been affected by the deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. The ice machine was taken out of service until 12/30/2024 when a descaling chemical was used to remove the scale buildup. The ice machine was not being cleaned on a regular basis and will now be cleaned daily. The manufacturer guideline recommends minimum time between internal cleanings at 6 months. The maintenance staff will complete inside cleaning every 6 months with the next cleaning completed within six months from December 30, 2024. The dietary manager will educate staff on correct ice machine cleaning practices on January 9th, 2025 during a scheduled dietary meeting. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The dietary manager will complete an audit on the cleaning of the ice machine weekly for the first 30 days by reviewing the log and inspecting the ice machine. This will be decreased to once per month audits for the next 60 days. The results will be reviewed at the February and May 2025 QAPI meeting.	

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	245588	A. BUILDING _____ B. WING _____	C 12/11/2024

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F 812	Continued From page 8	F 812	Identify who is responsible for the corrective actions and monitoring of compliance. The dietary manager is responsible for the corrective action and monitoring of compliance. The date that each deficiency will be corrected. January 9th, 2025	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F 880		1/10/25

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F 880	Continued From page 9 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 10 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an on-going infection control program which included comprehensive surveillance of resident infections including, signs and symptoms of infections, an antibiotic timeout (timeframe used after an antibiotic was initiated to ensure appropriate use and effectiveness) was performed and start/stop dates of antibiotics to prevent the spread of communicable disease and infections. This deficient practice had the potential to affect all 46 residents who resided in the facility. Findings include: A review of the facility's infection control surveillance log monthly report dated September - December 2024, revealed the following: -Columns on the log included resident name, the station resident resided on, if symptoms were present on admission, if the patient was hospitalized, date of onset symptoms, diagnosis, site of infection, the results if a culture was obtained, if an antibiotic was ordered, if a culture was re-obtained, precaution to prevent spread of infection, and date the symptoms were resolved. - The facility's current surveillance log lacked tracking necessary data which included: signs and symptoms for each infection, dates cultures were obtained, when the antibiotic was completed, when the antibiotic was discontinued, and when symptoms resolved.	F 880	St. William's Living Center Correction Plan for F-Tag 880 (Infection Prevention and Control) - Antibiotic Stewardship: Time-Out & Surveillance 1. Acknowledgement of Deficiency St. William's Living Center failed to establish an on-going infection control program which included comprehensive surveillance of resident infections including, signs and symptoms of infections, an antibiotic timeout (timeframe used after an antibiotic was initiated to ensure appropriate use and effectiveness) was performed and start/stop dates of antibiotics to prevent the spread of communicable disease and infections. This deficient practice had the potential to affect all 46 residents who resided in the facility. Refer to specific observations, resident incidents, or areas of non-compliance cited in the SOD. 2. Corrective Actions How corrective action will be accomplished for those residents found to have been affected by the deficient practices: -All residents charts reviewed for newly ordered antibiotics. One resident found. That resident did meet Loeb criteria, a culture was obtained, and antibiotic reviewed by provider. How the facility will identify other residents	

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F 880	Continued From page 11 -During the month of September 2024, the infection control surveillance log identified nine entries for infections. Five urinary tract infections (UTIs), three probable tooth infections, and one chronic obstructive pulmonary disease (lung condition) (COPD). No signs and symptoms were documented, no antibiotic time out was documented, no dates of when an antibiotic was started, no dates when the antibiotic was discontinued, and no room numbers were used. -During the month of October 2024, the infection control surveillance log identified that five antibiotics had been ordered. One for possible aspiration, one for diverticulitis (inflammation of the colon/anaplasmosis (illness caused by ticks), one for urinary tract infection, one for prophylaxis for nasal packing (prevent complications), and one for possible aspiration. There were no room numbers documented, no signs and symptoms documented, no dates when an antibiotic was started, no date when the antibiotic was discontinued, no antibiotic timeout documented, dates resolved were marked as not applicable (n/a) for a prophylaxis nasal packing and possible aspiration. During the month of November 2024, the infection control surveillance log identified that 12 antibiotics had been ordered. One for a toe infection, two for chronic obstructive pulmonary disease (COPD), two for respiratory infection, one for cystitis (inflammation of the bladder), two for cellulitis (bacterial skin infection), two for yeast infections, and two for urinary tract infection. No room numbers were used, no signs and symptoms were documented, no start dates for antibiotics, no stop dates for antibiotics and no	F 880	having the potential to be affected by the same deficient practice: - All residents charts reviewed for newly ordered antibiotics. One resident found. That resident did meet Loeb criteria, a culture was obtained, and antibiotic reviewed by provider. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: Enhance Antibiotic Time-Out Process: - Develop/Revise Time-Out Policy: -A clear and precise policy was established to conduct antibiotic time-outs. Time-outs will be conducted on all antibiotics started, aside from prophylactics. We will reassess the clinical status of the resident, review symptoms and culture results. Consideration of de-escalation or discontinuation will be determined by the doctor. Licensed nursing staff will be responsible for filling out and sending the antibiotic timeout form to the doctor 48-72 hours after the start of the antibiotic. The physician will be responsible for clinical decision making regarding continuing, de-escalating, or discontinuing the antibiotic. To ensure consistency the MDH 72-hour antibiotic time-out form will be utilized. An RN will run an antibiotic start report every Monday, Wednesday, and Friday for the previous three days and ensure all time-outs were and are completed. This will begin 12/27/2024. All RNs responsible will be educated. Implement Time-Out Procedures: -All licensed nursing staff will be trained on antibiotic time-out policies and	

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F 880	Continued From page 12 antibiotic timeouts. The date resolved was left blank for the yeast infection. -During the month of December 2024 the infection control surveillance log identified one antibiotic was ordered, the date of onset was 12/2/24, the diagnosis was for respiratory symptoms, the site of infection was respiratory, no culture was documented, no start date for an antibiotic, no antibiotic stop date, no antibiotic timeout was documented and no room number was documented. The date resolved is blank. During an interview on 12/11/24 at 11:24 a.m., infection preventionist (IP) stated she was responsible for overseeing the facility's infection control program and maintaining the facility's infection control surveillance log. IP confirmed the facility's current surveillance log lacked necessary data which included; signs and symptoms for each infection, dates of cultures obtained, when an antibiotic was started, when an antibiotic was discontinued, if an antibiotic timeout was done, and when symptoms resolved. IP confirmed the date resolved was typically the time frame when the antibiotic regimen was completed not the time the symptoms or infections were resolved. During an interview on 12/11/24 at 1:10 p.m., director of nursing (DON) stated the IP was responsible for overseeing the facility infection control program and maintaining the facility's infection control surveillance log. DON confirmed the facility's current surveillance log lacked necessary data which included signs and symptoms for each infection, dates of cultures obtained, when the antibiotic was started, when the antibiotic was discontinued, if an antibiotic timeout was completed, and when symptoms	F 880	procedures. Attending providers and consulting pharmacist will also be educated. A visual calendar has been placed in a central location for all staff and the time-out will also be added to the daily working calendar. Results of each time-out will be documented in the resident's medical record. A new progress note has been developed to document the time-out form was completed and sent to the physician. Another progress note has been developed to document the physician’s recommendations upon return of the time-out form. The time-out form will also be scanned into the resident’s misc. tab in their electric medical record. Strengthen Surveillance Activities: - Expand Surveillance Scope: Expanding surveillance activities utilizing a new spreadsheet provided by MDH ICAR. We will utilize the resident’s electric health records and labs to input data to the surveillance spreadsheet. - Data Analysis and Reporting: Antibiotic surveillance data will be analyzed monthly to identify trends, patterns, and areas for improvement in antibiotic use. Reports summarizing surveillance findings will be developed and shared with relevant staff. Utilize data to inform staff of trends, provide additional training as needed in regards to infections. - Collaboration and Communication: Collaborate with local and regional experts through Care Ventures and utilizing our consulting pharmacist to enhance surveillance and data analysis. Communicate surveillance findings and best practices to staff through educational	

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F 880	Continued From page 13 resolved. The DON stated the expectation would be to have the surveillance log completed according to national standards to help prevent the spread of infectious diseases and infections A policy titled Infection Prevention and control manual dated 8/23/24, revealed essential elements of a surveillance system included: Standardized definitions and listing of the symptoms of infections based upon national standards of practice. Sources of relevant data that can be used for outcome surveillance for infections, antibiotic use and susceptibility may include: -monitoring a resident with a fever or other signs that may indicate an infection, -laboratory cultures or other diagnostic test results consistent with potential infections to detect clusters, -trends, or susceptibility patterns, -antibiotic orders, -laboratory antibiograms (antibiotic susceptibility profiles), -medication regimen review reports. -The infection preventionist collects and reviews data on an ongoing basis including: -elevations in temperatures/ presence of fever, -purulent drainage, -culture results or other diagnosis test results consistent with potential infections, -change in x-ray results consistent with possible infection, -increased falls, -change in mental status, -change in vital signs, -signs and symptoms of infection based upon nationally accepted surveillance definitions (i.e. CDC/SHEA position statement: surveillance definitions of infections in long-term care facilities:	F 880	sessions, newsletters, or other appropriate methods. 3. Implementation Timeline - Implementation and all necessary education regarding antibiotic time-outs will be completed by January 10th, 2025. Updated surveillance spreadsheet will be initiated January 1st, 2025. An audit will be conducted weekly to ensure timely and complete antibiotic time-outs are done. 4. Responsibility and Accountability How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: - The infection preventionist will be responsible for overseeing and implanting the corrective action for implementing antibiotic time-outs and updated surveillance spreadsheet. The infection preventionist will complete auditing to ensure time-outs are being completed weekly. Audits will be discussed quarterly at QAPI meeting. The DON will oversee the surveillance program and will review the data monthly and quarterly with the infection control report at the QAPI meeting. The date that each deficiency be corrected: Ftag #880 will be corrected by January 10th, 2025	

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F 880	Continued From page 14 revisiting the McGeer Criteria or NHSN). The infection preventionist would ensure data collection to complete a comprehensive monthly infection control log for surveillance activities on: -The infection site, -pathogen (if known), -signs and symptoms (which the surveillance log did not include) -resident location (room numbers not used, only what station they were on) -summary and analysis of number of residents and/or staff with infections, -observations of staff adherence to policies and procedures, -identification of outcomes that were unusual or unexpected that could potential lead to patterns, treads or outbreaks. The infection preventionist or designee would be able to identify any necessary interventions in order to identify trends or clusters for actions, the infection preventionist would keep an updated map of infections to identify any clusters or trends.	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 01/09/2024, by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/11/2024. At the time of this survey, St. Williams Living Center-Building 01 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies and the 2012 edition of NFPA 99, Health Care Facilities Code. 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 FORM 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 12/23/2024

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.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. St. Williams Living Center Building 01 is a 1-story building without a basement. The existing portion of the building was constructed at six different times. The original building was built 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 to be of Type V(111)	K 000		

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K 000	Continued From page 2 construction. In 2001 an addition was added to the northeast that was determined to be of Type V(111) construction. Finally, in 2007 an addition was added to the southeast that was determined to be of Type II(111) Construction. Since the original building and all existing additions conform to the construction type allowed for a building of this height, the existing portions were surveyed as one building at the least protective construction type of Type V(111). In 2019, and a 1-story addition of Type V(111) construction was built and will be surveyed as a separate building. St. Williams Living Center is fully protected throughout by an automatic fire sprinkler system. There is a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and the resident rooms and is monitored for automatic fire department notification. The facility is divided into separate smoke compartments. The facility has a capacity of 53 beds and had a census of 46 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.	K 353		12/20/24

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K 353	Continued From page 3 a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect the fire sprinkler system per NFPA 101 (2012 edition), Life Saftey Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.1.2(2). This deficient finding could have an isolated impact on residents within the facility. Findings include: On 12/11/2024 between 9:15 and 11:15 AM, it was revealed by observation that a sprinkler head in Storage Room 311 was showing signs of corrosion. An interview with the Administrator and Maintenance Director verified this deficient finding at the time of discovery.	K 353	a) Date sprinkler system last checked __6.3.2024_____ b) Who provided system test ___Summit Fire Protection___ c) Water system supply source __City of Parkers Prairie____ 1. A detailed description of the corrective action taken or planned to correct the deficiency. a. During the week of 12/16/2024, Summit Fire Protection was onsite and replaced the sprinkler head in room 311. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. a. The maintenance staff have been educated to notify the administrator if any other sprinkler heads are corroded. If additional heads are corroded, then the administrator will schedule a time for the sprinkler head to be replaced. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. a. During the annual sprinkler inspection, the administrator will	

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(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 353	Continued From page 4	K 353	communicate with the sprinkler contractor and maintenance staff to ensure that all sprinkler heads have been inspected for corrosion. The administrator has updated his task list to ensure that this week be completed at least annually. 4. Identify who is responsible for the corrective actions and monitoring of compliance. a. The administrator and maintenance director are responsible for the corrective action and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. a. 12/20/2024.	
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier doors per	K 374	1. A detailed description of the corrective action taken or planned to correct the	12/23/24

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 _____	**12/11/2024**

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 374	Continued From page 5 NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8, and 8.5.4.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 12/11/2024 between 9:15 and 11:15 AM, it was revealed by observation that the smoke barrier doors by room 414 did not close completely when released from the magnetic hold-open device leaving a gap between the door leaves. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 374	deficiency. a. On 12/23/2024, the maintenance staff adjusted the doors so that they will close properly and not leave a gap between the door leaves. The door closer was adjusted so there is more pressure applied when the door closes. The door and hinges were also adjusted so that the doors do not rub on the door frame 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. a. During each month's fire drill, maintenance staff will inspect all fire and smoke doors that are expected to close to ensure that the doors close properly. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. a. During each month's fire drill, maintenance staff will inspect all fire and smoke doors that are expected to close to ensure that the doors close properly. 4. Identify who is responsible for the corrective actions and monitoring of compliance. a. The administrator and maintenance director are responsible for the corrective action and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. a. 12/23/2024	

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 _____	**12/11/2024**

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	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 01/09/2024, by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/11/2024. At the time of this survey, St. Williams Living Center-Building 01 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies and the 2012 edition of NFPA 99, Health Care Facilities Code. 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 FORM 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A	K 000		

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

Electronically Signed | 12/23/2024

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 **01 - MAIN BUILDING 01** B. WING _____	**12/11/2024**

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 1 PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. St. Williams Living Center Building 01 is a 1-story building without a basement. The existing portion of the building was constructed at six different times. The original building was built 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	K 000		

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 _____	**12/11/2024**

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 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 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. Finally, in 2007 an addition was added to the southeast that was determined to be of Type II(111) Construction. Since the original building and all existing additions conform to the construction type allowed for a building of this height, the existing portions were surveyed as one building at the least protective construction type of Type V(111). In 2019, and a 1-story addition of Type V(111) construction was built and will be surveyed as a separate building. St. Williams Living Center is fully protected throughout by an automatic fire sprinkler system. There is a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and the resident rooms and is monitored for automatic fire department notification. The facility is divided into separate smoke compartments. The facility has a capacity of 53 beds and had a census of 46 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing,	K 353		12/20/24

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 _____	**12/11/2024**

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 353	Continued From page 3 and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect the fire sprinkler system per NFPA 101 (2012 edition), Life Saftey Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.1.2(2). This deficient finding could have an isolated impact on residents within the facility. Findings include: On 12/11/2024 between 9:15 and 11:15 AM, it was revealed by observation that a sprinkler head in Storage Room 311 was showing signs of corrosion. An interview with the Administrator and Maintenance Director verified this deficient finding at the time of discovery.	K 353	a) Date sprinkler system last checked __6.3.2024_____ b) Who provided system test ___Summit Fire Protection___ c) Water system supply source __City of Parkers Prairie____ 1. A detailed description of the corrective action taken or planned to correct the deficiency. a. During the week of 12/16/2024, Summit Fire Protection was onsite and replaced the sprinkler head in room 311. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. a. The maintenance staff have been educated to notify the administrator if any other sprinkler heads are corroded. If additional heads are corroded, then the administrator will schedule a time for the	

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 _____	**12/11/2024**

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

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K 353	Continued From page 4	K 353	sprinkler head to be replaced. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. a. During the annual sprinkler inspection, the administrator will communicate with the sprinkler contractor and maintenance staff to ensure that all sprinkler heads have been inspected for corrosion. The administrator has updated his task list to ensure that this week be completed at least annually. 4. Identify who is responsible for the corrective actions and monitoring of compliance. a. The administrator and maintenance director are responsible for the corrective action and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. a. 12/20/2024.	
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for	K 374		12/23/24

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 _____	**12/11/2024**

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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K 374	Continued From page 5 swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8, and 8.5.4.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 12/11/2024 between 9:15 and 11:15 AM, it was revealed by observation that the smoke barrier doors by room 414 did not close completely when released from the magnetic hold-open device leaving a gap between the door leaves. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 374	1. A detailed description of the corrective action taken or planned to correct the deficiency. a. On 12/23/2024, the maintenance staff adjusted the doors so that they will close properly and not leave a gap between the door leaves. The door closer was adjusted so there is more pressure applied when the door closes. The door and hinges were also adjusted so that the doors do not rub on the door frame 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. a. During each month's fire drill, maintenance staff will inspect all fire and smoke doors that are expected to close to ensure that the doors close properly. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. a. During each month's fire drill, maintenance staff will inspect all fire and smoke doors that are expected to close to ensure that the doors close properly. 4. Identify who is responsible for the corrective actions and monitoring of compliance. a. The administrator and maintenance director are responsible for the corrective action and monitoring of compliance. 5. The actual or proposed date for completion of the remedy.	

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 _____	**12/11/2024**

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K 374	Continued From page 6	K 374	a. 12/23/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245588	A. BUILDING **03 - 14 BED ADDITION** B. WING _____	**12/11/2024**

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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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/11/2024. At the time of this survey, St. Williams Living Center was found 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) 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies and the 2012 edition of NFPA 99, the Health Care Facilities Code. St. Williams Living Center Building 03 is a 1-story addition without a basement that was added to the original building in 2019. The new addition was built of Type V (111) construction. The addition is fully protected throughout by an automatic fire sprinkler system. In addition, there is a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and the resident rooms and is monitored for automatic fire department notification. The addition is an entire single smoke compartment. The facility has a capacity of 53 beds and had a census of 46 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

Electronically Signed | 12/23/2024

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.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 20, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: 8OZL11

Dear Administrator:

The above facility was surveyed on December 9, 2024 through December 11, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

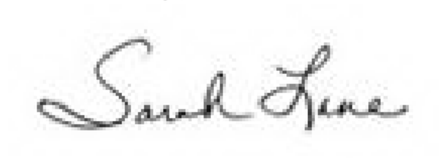
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00444	A. BUILDING: _____ B. WING _____	C 12/11/2024

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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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/9/24 to 12/11/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). A complaint survey was also conducted. Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00444	A. BUILDING: _____ B. WING _____	C 12/11/2024

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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2 000	Continued From page 1 correction you have reviewed these orders and identify the date when they will be completed. The following complaint was reviewed during the survey: H55881373C (MN00101497). No licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		

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	00444	A. BUILDING: _____ B. WING _____	C 12/11/2024

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, food was not served in a sanitary manner for 15 residents who dined in the north dining area, observed during dining services. In addition, the facility failed to maintain the ice machine in a sanitary manner to prevent potential illness for 15 residents who currently received ice from the ice machine in the north dining area. Further, the facility failed to maintain proper holding food temperatures for 13 of 17 residents observed to receive egg salad sandwiches. These deficient practices had the potential to cause foodborne illness. Findings include: FOOD SERVICE	21015	Corrected.	1/10/25

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21015	Continued From page 3 During an observation on 12/10/24 at 12:06 p.m., dietary aide (DA)-A washed her hands in the north kitchen, applied gloves to both hands, picked up an i-pad with resident dietary information on it and placed it on the counter next to the steam trays. DA-A opened a drawer with her left hand, removed utensils from the drawer with both hands and placed utensils into each food item on the steam tray area. DA-A proceeded to open a bag of buns, touched the i-pad with her left hand, picked up a baked potato with her right hand and placed the potato onto a plate. DA-A opened the potato with both hands and a knife and placed other food items on the plate with utensils and handed the plate to the server. DA-A touched the i-pad with her left hand, picked up a bun with her left hand and placed onto the plate. DA-A picked up a baked potato with her right hand, placed onto the plate, opened the potato with both hands and a knife, then placed other food items on the plate with utensils and handed the plate to the server. DA-A continued to touch the i-pad in between each resident served, picked up a bun and or a baked potato with her gloved hands for all residents who received a bun and or baked potato. DA-A then opened a kitchen cupboard with the same gloved hand, removed a salt shaker and handed it to the server. DA-A continued to touch the i-pad in between each resident's meal setup, placed a bun and or baked potato onto residents plates for the remaining of the lunch meal wearing the same pair of gloves. At no time during the observation did DA-A wash hands and re-apply new gloves. During an interview on 12/10/24 at 1:40 p.m., DA-A confirmed she touched the i-pad frequently throughout the meal service, touched the cupboard/drawer and then touched the buns and	21015		

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21015	Continued From page 4 baked potatoes while wearing the same pair of gloves and without washing her hands. DA-A stated the i-pad was to be cleaned after each shift with an alcohol wipe and the i-pad had not been cleaned prior to meal service. DA-A stated other staff used the i-pad during the day to assist residents with deciding their meals for each day. DA-A stated the cupboards and drawers were not on a schedule to be cleaned. DA-A stated staff should not touch food with gloved hands if the gloves have touched other objects as germs could get onto the residents food. During an interview on 12/10/24 at 1:55 p.m., dietary manager (DM) verified the expectation of staff would be to wash hands and change gloves when the staff touched non-food items. DM confirmed it was important to prevent the spread of germs to the residents and could cause food-borne illness. ICE MACHINE During an observation of the north kitchen area on 12/10/24 at 11:27 a.m., the ice and water machine spouts on the ice machine had a white powder substance approximately one fourth to one half an inch in height around the entire inside and outside of both spouts. In addition, there was a white powder substance present expanding across the entire drain plate below the ice and water spouts. During an interview on 12/10/24 at 1:55 p.m., DM confirmed a white powder substance was present on the ice and water spouts of the ice machine. DM stated the facility had issues with the ice machine leaking. DM stated there was no cleaning process in place for the ice machine. DM stated the white powder substance had the	21015		

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21015	Continued From page 5 potential to spread germs to the residents. During an interview on 12/11/24 at 8:56 a.m., maintenance staff stated the ice machine dripped when the ice melted and the machine was cleaned every three months. Maintenance staff stated the facility did not keep a log to verify cleaning of the ice machine. Maintenance staff stated the white powder substance could have bacteria present and residents could develop illness as a result. FOOD TEMPERATURE During an observation on 12/9/24 at 4:45 p.m., DA-B entered the north kitchen with a cart of food from the main kitchen. DA-B placed hot food items on the steam trays and proceeded to obtain beverages and fruit cups from the fridge and delivered to each resident table. DA-B placed a plastic tray with six egg salad sandwiches from the cart on the counter next to the steam tray and placed a small bowl of egg salad on the counter next to the sandwiches. During continued observation at 5:12 p.m., DA-B temped the egg salad in the bowl at 50 degrees. DA-B temped an egg salad sandwich at 55.7 degrees. DA-B started to place an egg salad sandwich onto a resident place when surveyor intervened and asked DA-B what the recommended temperature for cold food would be. DA-B looked at the facility food temp log to see what the recommended cold food holding temperature should be. DA-B then placed the egg salad bowl and sandwiches in the freezer. During an observation on 12/9/24 at 5:19 p.m., three and a half egg salad sandwiches were on the center counter on a plastic tray in the main kitchen. The cook temped the egg salad	21015		

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21015	Continued From page 6 sandwich at 51.6 degrees. During an interview on 12/9/24 at 5:44 p.m., the cook stated the egg salad sandwiches were removed from the walk in fridge prior to food service and placed onto the center counter. The cook stated cold sandwiches were usually placed on a plastic tray and served from the center counter. The cook verified cold sandwiches were not put on ice. The cook stated cold food items holding temperature should be under 41 degrees to prevent residents from becoming ill. During an interview on 12/10/24 at 9:22 a.m., DM confirmed the expectation staff were to temp foods prior to serving and if a cold food was not in the recommended holding temperature, staff would place the food back in the fridge and re-temp prior to serving. DM stated the process was important to prevent foodborne illness. During an interview on 12/11/24 at 10:26 a.m., dietician confirmed the expectation staff would be to have cold foods on an ice-bath during food service. Dietician verified it was important to maintain holding temperatures, to prevent foodborne illness and bacteria growth, and to ensure quality of food for the residents. The Food and Drug Administration food code identified the danger zone refers to the range of temperatures at which bacteria can grow between 40 degrees Fahrenheit (F) and 140 degrees F. For food safety, keep food below or above the "danger zone." A facility policy titled Food Safety Requirements dated 1/25/23, food service safety referred to handling, preparing, and storing food in ways that prevented foodborne illness. Staff would monitor	21015		

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21015	Continued From page 7 food temperatures while holding for delivery to ensure proper hot and cold holding temperatures were maintained. Staff would refer to the current Food and Drug Administration (FDA) food code and facility policy for food temperatures. Foods and beverages would be distributed and served to residents in a manner to prevent contamination and maintain food at the proper temperature and out of the Danger Zone. Staff would not touch food with bare hands, exhibiting appropriate use of gloves. Gloves would be worn when directly touching ready-to-eat foods. A facility policy titled Sanitization of I-Pad Screen dated 10/3/23, identified staff were to clean the screen, sides, and back of the I-pad with an alcohol wipe before and after each meal and let air dry. A facility policy titled Ice Chests and Machines undated, identified the facility was to keep the ice machine clean and sanitary to prevent contamination. The ice machine would be drained, cleaned and sanitized according to manufacturer's specification. The tray would be run through a dishwasher or sterilized daily. A manufacturer form provided by the facility titled Scotsman Ice Systems dated September 2020, identified over time the drip tray and cup rest/spouts may become coated with scale or dirt. They could be removed and scrubbed in a sink. The spouts/chutes and drip tray were to be washed and to use ice machine scale remover if needed to dissolve scale. Recommended cleaning the ice machine every six months and more frequent cleanings may be required based on the mineral content of the water, run time and potential airborne contamination.	21015		

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21015	Continued From page 8 SUGGESTED METHOD OF CORRECTION: The RD or designee, could develop policy and procedures for ensuring sanitary conditions while serving food and for maintaining ice machines. In addition, the RD or designee could develop policy and procedures for ensuring holding temperatures for food were within guidelines. The RD or designee, could conduct random audits during food service to ensure sanitary serving practices while serving food and beverages. In addition, the RD or designee could conduct random audits to ensure proper cleaning for ice machines. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to establish an on-going infection control program which included comprehensive surveillance of resident infections including, signs and symptoms of infections, an antibiotic timeout (timeframe used after an antibiotic was initiated to ensure appropriate use and effectiveness) was performed and start/stop dates of antibiotics to prevent the spread of communicable disease and infections. This deficient practice had the potential to affect all 46 residents who resided in	21375	Corrected.	1/10/25

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21375	Continued From page 9 the facility. Findings include: A review of the facility's infection control surveillance log monthly report dated September - December 2024, revealed the following: -Columns on the log included resident name, the station resident resided on, if symptoms were present on admission, if the patient was hospitalized, date of onset symptoms, diagnosis, site of infection, the results if a culture was obtained, if an antibiotic was ordered, if a culture was re-obtained, precaution to prevent spread of infection, and date the symptoms were resolved. - The facility's current surveillance log lacked tracking necessary data which included: signs and symptoms for each infection, dates cultures were obtained, when the antibiotic was completed, when the antibiotic was discontinued, and when symptoms resolved. -During the month of September 2024, the infection control surveillance log identified nine entries for infections. Five urinary tract infections (UTIs), three probable tooth infections, and one chronic obstructive pulmonary disease (lung condition) (COPD). No signs and symptoms were documented, no antibiotic time out was documented, no dates of when an antibiotic was started, no dates when the antibiotic was discontinued, and no room numbers were used. -During the month of October 2024, the infection control surveillance log identified that five antibiotics had been ordered. One for possible aspiration, one for diverticulitis (inflammation of the colon/anaplasmosis (illness caused by ticks),	21375		

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21375	Continued From page 10 one for urinary tract infection, one for prophylaxis for nasal packing (prevent complications), and one for possible aspiration. There were no room numbers documented, no signs and symptoms documented, no dates when an antibiotic was started, no date when the antibiotic was discontinued, no antibiotic timeout documented, dates resolved were marked as not applicable (n/a) for a prophylaxis nasal packing and possible aspiration. During the month of November 2024, the infection control surveillance log identified that 12 antibiotics had been ordered. One for a toe infection, two for chronic obstructive pulmonary disease (COPD), two for respiratory infection, one for cystitis (inflammation of the bladder), two for cellulitis (bacterial skin infection), two for yeast infections, and two for urinary tract infection. No room numbers were used, no signs and symptoms were documented, no start dates for antibiotics, no stop dates for antibiotics and no antibiotic timeouts. The date resolved was left blank for the yeast infection. -During the month of December 2024 the infection control surveillance log identified one antibiotic was ordered, the date of onset was 12/2/24, the diagnosis was for respiratory symptoms, the site of infection was respiratory, no culture was documented, no start date for an antibiotic, no antibiotic stop date, no antibiotic timeout was documented and no room number was documented. The date resolved is blank. During an interview on 12/11/24 at 11:24 a.m., infection preventionist (IP) stated she was responsible for overseeing the facility's infection control program and maintaining the facility's infection control surveillance log. IP confirmed the	21375		

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21375	Continued From page 11 facility's current surveillance log lacked necessary data which included; signs and symptoms for each infection, dates of cultures obtained, when an antibiotic was started, when an antibiotic was discontinued, if an antibiotic timeout was done, and when symptoms resolved. IP confirmed the date resolved was typically the time frame when the antibiotic regimen was completed not the time the symptoms or infections were resolved. During an interview on 12/11/24 at 1:10 p.m., director of nursing (DON) stated the IP was responsible for overseeing the facility infection control program and maintaining the facility's infection control surveillance log. DON confirmed the facility's current surveillance log lacked necessary data which included signs and symptoms for each infection, dates of cultures obtained, when the antibiotic was started, when the antibiotic was discontinued, if an antibiotic timeout was completed, and when symptoms resolved. The DON stated the expectation would be to have the surveillance log completed according to national standards to help prevent the spread of infectious diseases and infections A policy titled Infection Prevention and control manual dated 8/23/24, revealed essential elements of a surveillance system included: Standardized definitions and listing of the symptoms of infections based upon national standards of practice. Sources of relevant data that can be used for outcome surveillance for infections, antibiotic use and susceptibility may include: -monitoring a resident with a fever or other signs that may indicate an infection, -laboratory cultures or other diagnostic test results consistent with potential infections to detect clusters,	21375		

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21375	Continued From page 12 -trends, or susceptibility patterns, -antibiotic orders, -laboratory antibiograms (antibiotic susceptibility profiles), -medication regimen review reports. -The infection preventionist collects and reviews data on an ongoing basis including: -elevations in temperatures/ presence of fever, -purulent drainage, -culture results or other diagnosis test results consistent with potential infections, -change in x-ray results consistent with possible infection, -increased falls, -change in mental status, -change in vital signs, -signs and symptoms of infection based upon nationally accepted surveillance definitions (i.e. CDC/SHEA position statement: surveillance definitions of infections in long-term care facilities: revisiting the McGeer Criteria or NHSN). SUGGESTED METHOD OF CORRECTION : The facility could review polices and procedures related to infection surveillance. The Infection Preventionist or designee could audit to ensure proper infection surveillance. TIME FOR CORRECTION: Twenty-one (21) days.	21375		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 15, 2025

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

RE: CCN: 245588
Cycle Start Date: December 11, 2024

Dear Administrator:

On January 14, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 15, 2025

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

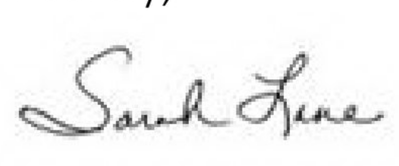
Re: Reinspection Results
Event ID: 8OZL12

Dear Administrator:

On January 14, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 11, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,



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