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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: JV6F

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00444

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245588**
2.STATE VENDOR OR MEDICAID NO.
(L2) **887342900**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST WILLIAMS LIVING CENTER**
(L4) **212 WEST SOO STREET, BOX 30**
(L5) **PARKERS PRAIRIE, MN** (L6) **56361**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/06/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Beth Nowling, HFE NEII 07/19/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/10/2016 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/29/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245588

August 10, 2016

Mr. Tim Kelly, Administrator
St Williams Living Center
212 West Soo Street, Box 30
Parkers Prairie, Minnesota 56361

Dear Mr. Kelly:

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

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

Effective June 28, 2016 the above facility is certified for:

53 Skilled Nursing Facility/Nursing Facility Beds

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

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 19, 2010

Mr. Tim Kelly, Administrator
St Williams Living Center
212 West Soo Street, Box 30
Parkers Prairie, Minnesota 56361

RE: Project Number S5588027

Dear Mr. Kelly:

On May 25, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standarsurvey, completed on May 12, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F). whereby corrections were required.

On July 6, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 6, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 12, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 28, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 12, 2016, effective June 28, 2016 and therefore remedies outlined in our letter to you dated May 25, 2016, will not be imposed.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245588		7/6/2016

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 06/16/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [X]	REVIEWED BY (INITIALS) GA/mm	DATE 07/19/2016	SIGNATURE OF SURVEYOR 34088	DATE 07/06/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 5/12/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO			

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245588 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	7/6/2016 (Y3)

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 06/28/2016	ID Prefix Reg. # NFPA 101 LSC K0069	Correction Completed 05/13/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	GA/mm	07/19/2016	36536	07/06/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
5/12/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: JV6F

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00444

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245588**

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

3. NAME AND ADDRESS OF FACILITY
(L3) **ST WILLIAMS LIVING CENTER**
(L4) **212 WEST SOO STREET, BOX 30**
(L5) **PARKERS PRAIRIE, MN** (L6) **56361**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/12/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Beth Nowling, HFE NEII — 06/15/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 06/29/2016 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
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3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 25, 2016

Mr. Tim Kelly, Administrator
St Williams Living Center
212 West Soo Street, Box 30
Parkers Prairie, Minnesota 56361

RE: Project Number S5588027

Dear Mr.. Kelly:

On May 12, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 21, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 21, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 12, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 12, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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 _____	05/12/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441		6/16/16

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

Electronically Signed | 06/14/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245588	A. BUILDING _____ B. WING _____	05/12/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 1 (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement infection control practices to prevent the potential for the spread of infection for 1 of 1 resident (R27) diagnosed with Chickenpox. In addition, the facility failed to implement their protocol for reporting an outbreak of gastroenteritis to the State agency. This had the potential to affect all 52 residents in the facility. Findings include: R27's Physician ' s orders form identified an order prescribed 5/10/16, "1 gram valacyclovir (an antiviral used to treat Chickenpox, shingles, cold sores and genital herpes) po (by mouth) TID (three times a day) x 7 days for the diagnosis of zoster (Varicella-zoster virus the cause of chickenpox and herpes zoster.)" R27's care plan revised 5/10/2016, indicated R27	F 441	F441 Based on observation, interview and document review, the facility failed to implement infection control practices to prevent the potential for the spread of infection for 1 of 1 resident (R27) diagnosed with Chickenpox. The organization□s infection control isolation policy was reviewed and updated. The infectious disease short term care plan was updated and will be kept on the infection control cart in a binder so that staff may refer to the short term care plan immediately prior to entering the room to assure that they are following all the protocols and interventions while providing cares. A list of precautions will also be included in the binder for staff to review. Competencies	

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F 441	Continued From page 2 had the diagnosis of Chickenpox. The care plan interventions included door closed at all times, droplet and contact precautions, last room of the day to be cleaned, laundry red bagged and washed separately, meals in her room, no pregnant staff in room, that have not had the chicken pox virus. R27's nursing assistant (NA) care sheet (not dated) directed R27's care to include droplet and contact precautions, gown, glove and mask, door closed at all times, last room of the day to be cleaned and meals in her room. Review of R27's progress notes revealed a note dated 5/11/16. The note identified R27 continued to have pustule like rash present to multiple areas bilaterally. The areas were noted to be weepy and crystallized drainage present. Further, the note listed contact and droplet precautions as well as anti-viral therapy was to be continued. On 5/11/16, from 7:30 a.m. to 8:02 a.m. nursing assistant (NA)-A and NA-B provided morning cares for R27. NA-A and NA-B wore personal protective items including gown, mask and gloves. NA-B washed and dried R27's face, neck and body as NA-A assisted to remove gown and assist with R27's body position in bed. While providing care of R27 NA-A pushed her hair behind her ears while she wore the gloves handling R27's linens and body. Licensed practical nurse (LPN)-A approached the bed to obtain a urine sample from R27's catheter tubing. NA-A assisted LPN-A and held the tubing and other items to change the catheter bag from a straight drainage bag to a leg bag. While NA-A assisted with the urine bag change, she reached up with her gloved hands and pushed the hair	F 441	will be completed with all nursing staff regarding putting on and off PPE equipment, handwashing, and the importance of putting hair in a ponytail while performing cares. These competencies will be completed by June 16, 2016, and also upon hire and annually. Random audits of PPE and handwashing will be completed monthly on an ongoing basis. Results of the audits will be reviewed immediately with staff and education will be provided if necessary. The audits will be reviewed at bi-monthly safety meetings and quarterly Quality Assurance meetings to review trends and plan education. The facility failed to implement their protocol for reporting an outbreak of gastroenteritis to the State agency. This had the potential to affect all 52 residents in the facility. The organization□s Reporting of Diseases for Public Health Purposes and Management of Gastrointestinal Illness/Outbreak policies were reviewed and updated. The Minnesota Department of Health Foodborne Illness department was contacted and the requested information about the December 2015 GI outbreak was faxed. This information included the infection control summary, 3 page resident GI log, and a 2 page employee GI log. The organization will be monitoring for patterns of infections that indicate an outbreak at daily report meetings and weekly by the infection	

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F 441	Continued From page 3 away from her face and tucked it behind her ears. NA-A immediately reached out to hold the urine bag and equipment to assist with the bag change. NA-A repeated tucking her hair behind her ears while handling and assisting with the bag change during the procedure. After the bag change was completed, NA-A immediately assisted R27 to don a shirt and to sit up on the edge of the bed. NA-A again pushed her hair away from her face and tucked it behind her ears with the same soiled gloved hands. NA-A assisted NA-B with a standing lift to transfer R27 into a wheel chair. NA-A gathered R27's soiled washcloth, towel and gown, placed them into an opaque garbage bag and with the same soiled gloved hands once again pushed her hair behind both ears. NA-A had not changed her gloves or performed hand hygiene during the entire observation. On 5/11/2016, at 8:07 a.m. NA-A verified R27's linens were contaminated as well as the gloves worn on her hands. NA-A indicated she was not aware she had touched her face and hair with the contaminated gloves. She indicated she would place her hair into a ponytail in order to prevent touching her hair and face again. On 5/11/2016, at 8:24 a.m. NA-B was observed in R27's room without glove, gown or mask worn.. NA-B walked towards the door from the opposite end of R27 ' s room, walked between the television and R27 who was seated in a wheel chair in the center of the room. NA-B adjusted the over the bed table into position in front of R27 and then walked out the door of the room. NA-B was within three feet of R27 and handled a surface which was directly in front of R27. On 5/11/2016, at 8:24 a.m. NA-B verified she	F 441	preventionist. Infection control reports are also reviewed at bi-monthly safety meetings and quarterly Quality Assurance meetings. Education was provided to review the updated policies and procedures at nurses meeting on June 7, 2016 and in house CNA in-services from June 8, 2016 through June 16, 2016. The medical director was updated about the revised polices on June 14, 2016. The DON, Infection Preventionist, and QA Committee are responsible for implementing this POC.	

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F 441	Continued From page 4 had entered R27's room without the use of gloves, gown and mask. NA-B indicated she felt the protective wear was only to be worn when providing personal cares for R27. On 5/11/2016, at 10:51 a.m. registered nurse (RN)-A verified she was responsible for the facility infection control program. RN-A identified R27 had contact and droplet precautions in place at this time due to possible diagnosis of Chickenpox. RN-A identified these precautions included the use of gown, glove and mask. RN-A verified staff were expected to follow contact and droplet precautions for R27. RN-A verified gloves used during personal cares for R27 would have been contaminated. RN-A indicated facility policy directed staff to use protective equipment when staff were within 3 feet of R27, anytime R27 ' s soiled linen was handled, and verified with the distance between where R27 was seated in the room and the television, staff would have needed to wear the protective equipment. On 5/11/2016, at 11:00 a.m. the director of nursing (DON) verified R27's current physician diagnosis of Chickenpox, treatment with an antiviral and care planned droplet and contact precautions to include glove, gown and mask when entering R27's room, DON verified staff were expected to follow the care plan including following the contact and droplet precautions, staff should not touch themselves with gloves worn for care of R27 and staff to be gloved, gowned and masked if within 3 feet of R27. Review of the facility Infection Control Log identified:	F 441		

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F 441	Continued From page 5 -November 2015, the facility had zero incidences of Gastrointestinal infection. -December 2015, the facility had 19 identified cases of resident's (37% of residents infected) who had GI symptoms which affected resident's living on all units. In addition, 16 nursing staff were also identified with GI symptoms during the same time period. On 5/12/16, at 10:40 a.m. registered nurse (RN)-A confirmed policies and infection control data from 12/15. She stated she reviewed infection control data each month, data was reviewed again during their safety meetings and was reviewed again during the facility quality assurance meeting. She stated she should have reported the December GI illnesses to the state agency, but didn't recognize it should have been reported. She stated infected residents had loose stools and emesis. RN-A confirmed 19 residents and 16 nursing staff were infected with GI illness 12/15 and the facility census was 52 during that time. She stated they kept sick residents in their rooms, limited activities and visitors, and encouraged handwashing during the period of GI illness. On 5/12/16, at 10:52 a.m. the director of nursing (DON) stated RN-A was responsible for the infection control program and evaluated the data. She stated if RN-A identified an increase in GI illness she would notify the DON and administrator, and they would determine whether it was an outbreak and either herself, RN-A or both would report it to the state agency. The DON stated the term, "Outbreak," was the area they needed to clarify. The DON stated over the years	F 441		

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F 441	Continued From page 6 this wasn't uncommon (referring to the degree of GI illness in the facility). She stated she felt they made the best judgement at the time with the information they had and stated, "Could the decision have been better? maybe, but we can't go back." She confirmed the polices and infection control data from 12/15. She stated it made sense to have reported it, and they could learn from this. DON stated she did not recognize this was reportable to the state agency, and if they had known they would have reported it. The facility form titled Infection Control Transition-Based Precautions, (not dated) identified the following: Contact - direct contact with skin, or indirect contact with contaminated surfaces, and physical transfer of organisms (usually on hands of health care workers) from an infected or colonized person to a susceptible host. Procedure for contact precautions: Gloves-wear gloves whenever touching the resident ' s intact skin or surfaces and articles in close proximity to the resident. Gowns- Don gown upon entry into the room or cubicle. Droplet- small droplets that contain an infectious organism that can be expelled for up to three feet by coughing or sneezing. A susceptible host can contract infection by inhaling these organisms or through contact with mucous membranes (eyes, nose, mouth). Procedure for droplet precautions- Don a mask upon entry into the resident room or cubicle. The facility's Care Plan policy revised May 2016, identified the purpose: "To ensure that resident care planned (sik) is appropriate and will be	F 441		

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F 441	Continued From page 7 carried out consistently by all personnel to meet each resident's specific needs." The facility's Infection Control Policy dated 3/16, indicated an increased incidence of any illness beyond the expected number of cases in a given period, which may indicate a newly recognized infectious agent, an outbreak, epidemic, or related public health hazard, which included suspected or confirmed outbreaks of viral gastroenteritis would be reported immediately by phone by the person who had knowledge to the Department of Health Infectious Disease Division.	F 441		

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	245588	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/12/2016**

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

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K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. Williams Living Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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K 000	Continued From page 1 Or by email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The facility was inspected as two separate buildings: St. Williams Living Center is a 1-story building with no basement. The building was constructed at 6 different times. The original building was constructed in 1963 and was determined to be type II(000) construction. In 1967 an addition was added to the south that was determined to be of Type II(111) construction. In 1976 an addition was added to the west that was determined to be of Type II(111) construction. In 1996 additions were added to the northwest that was determined to be of Type V(111) construction. In 2001 an addition was added to the northeast that was determined to be of Type V(111) construction. In 2007 an addition was added to the southeast that was determined to be of Type II(111) Construction.	K 000		

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K 000	Continued From page 2 The building is fully fire sprinklered throughout. The facility has a fire alarm system that includes smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 53 beds and had a census of 51 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke resistance of 1 corridor door according to NFPA 101 LSC (00) section 19.3.6.3.1. This deficient practice could affect the safety of 22 of the 53 residents and an undetermined amount of staff and visitors, if smoke from a fire were allowed to enter the exit	K 018	A replacement door for room 308 was ordered on May 17, 2016 through Simonson Lumber. The door will be delivered and installed replacing the current door by June 28, 2016.	6/28/16

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K 018	Continued From page 3 access corridors making it untenable. Findings include: On the facility tour between 8:00 am to 11:00 am on 05/12/2016 observations and staff interview revealed resident room door 308 does not fit tightly in the frame to resist the passage of smoke. This deficient condition was verified by the Facility Administrator and the Maintenance Director	K 018		
K 069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined that the facility has failed to complete both of the semi-annual inspections of the kitchen hood system per NFPA 96 8-3.1 Lack of proper testing and maintenance does not ensure the proper operation of all hood components and could allow a build up of grease, which could result in fire. This deficient practice could affect 13 of the 39 residents, all kitchen staff and visitors. Findings Include: On the facility tour between 8:00 am to 11:00 am on 05/12/2016 record review and staff interview revealed the kitchen exhaust hood was inspected once in the last 12 months. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor.	K 069	On May 12, 2016, Summit Companies was contacted to update the life safety code agreement with St. William's Living Center. Summit Companies will now inspect the kitchen exhaust hood every 6 months. The kitchen exhaust hood was last inspected April 27, 2016. As of May 13, 2016, Summit Companies has agreed to inspect the kitchen exhaust hood within 6 months from April 27, 2016.	5/13/16

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	245588	A. BUILDING **02 - NEW BLDG** B. WING _____	**05/12/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY Bldg 02 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St Williams Living Center Building 01 was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The facility was inspected as two separate buildings: St. Williams Living Center is a 1-story building with no basement. The building was constructed at 6 different times. The original building was constructed in 1963 and was determined to be type II(000) construction. In 1967 an addition was added to the south that was determined to be of Type II(111) construction. In 1976 an addition was added to the west that was determined to be of Type II(111) construction. In 1996 additions were added to the northwest that was determined to be of Type V(111) construction. In 2001 an addition was added to the northeast that was determined to be of Type V(111) construction. In 2007 an addition was added to the southeast that was determined to be of Type II(111) Construction. The building is fully fire sprinklered throughout. The facility has a fire alarm system that includes smoke detection in the corridors and spaces	K 000	EPOC	

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245588	A. BUILDING **02 - NEW BLDG** B. WING _____	**05/12/2016**

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 open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 53 beds and had a census of 51 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		