### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: P04Q

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

PART	I - TO BE COMPLI	ETED BY T	HE STAT	TE SURVEY AGENCY	Facility ID: 00444
MEDICARE/MEDICAID PROVIDER NO.     (L1)	3. NAME AND ADDRESS OF FACILITY (L3) ST WILLIAMS LIVING CENTER (L4) 212 WEST SOO STREET, BOX 30 (L5) PARKERS PRAIRIE, MN			(L6) <b>56361</b>	4. TYPE OF ACTION: 7 (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 6. DATE OF SURVEY 07/20/2017 (L34)	7. PROVIDER/SUPP 01 Hospital 02 SNF/NF/Dual			02 (L7) 13 PTIP 22 CLIA 14 CORF	7. On-Site Visit 9. Other 8. Full Survey After Complaint
8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	15 ASC 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)	B. Not in Comp	e With quirements Based On: ceptable POC	ram	And/Or Approved Waivers Of Th  2. Technical Personnel  3. 24 Hour RN  4. 7-Day RN (Rural SNI  5. Life Safety Code	6. Scope of Services Limit 7. Medical Director 8. Patient Room Size 9. Beds/Room
14. LTC CERTIFIED BED BREAKDOWN  18 SNF 18/19 SNF 19 SNF  53  (L37) (L38) (L39)	ICF (L42)	IID (L43)	vers:	* Code: <b>A</b> 15. FACILITY MEETS  1861 (e) (1) or 1861 (j) (1):	(L12) (L15)
<ul> <li>16. STATE SURVEY AGENCY REMARKS (IF APPLICAB Effective June 14, 2017, the five layaway nursing ho the number of certified SNF/NF beds are 53.</li> <li>17. SURVEYOR SIGNATURE</li> </ul>				e with the permanent delicensure	
Gail Anderson, Unit Supervisor		/20/2017	(L19)	Anne Peterson, Enforcem	
PART II - TO B	E COMPLETED B	Y HCFA RE	EGIONAL	OFFICE OR SINGLE ST	ATE AGENCY
DETERMINATION OF ELIGIBILITY      1. Facility is Eligible to Participate     2. Facility is not Eligible      (L21)		LIANCE WITH ( ITS ACT:	CIVIL		ncial Solvency (HCFA-2572) Il Interest Disclosure Stmt (HCFA-1513) :
22. ORIGINAL DATE 23. LTC AGREED OF PARTICIPATION BEGINNING 12/01/1991 (L24) (L41)		LTC AGREEM ENDING DATI		26. TERMINATION ACTION:  VOLUNTARY 00  01-Merger, Closure  02-Dissatisfaction W/ Reimbursement	05-Fail to Meet Health/Safety
A. Suspensio	IVE SANCTIONS on of Admissions: uspension Date:	(L44) (L45)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
28. TERMINATION DATE: 2	9. INTERMEDIARY/CA 03001	RRIER NO.	(L31)	30. REMARKS	
31. RO RECEIPT OF CMS-1539 3 (L32)	2. DETERMINATION OF <b>08/03/2017</b>	APPROVAL DA	ATE (L33)	DETERMINATION APPR	OVAL



CMS Certification Number (CCN): 245588 July 25, 2017

Mr. Tim Kelly, Administrator St. Williams Living Center 212 West Soo Street, Box 30 Parkers Prairie, MN 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 July 17, 2017 the above facility is recommended for:

53 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 53 skilled nursing facility beds. You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Licensing and Certification Program

Health Regulation Division

Aune Petenson

Minnesota Department of Health

P.O. Box 64900

St. Paul, MN 55164-0900 anne.peterson@state.mn.us

Telephone #: 651-201-4206 Fax #: 651-215-9697



Electronically delivered July 25, 2017

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

RE: Project Number S5588028

Dear Mr. Kelly:

On June 26, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 8, 2017. 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 20, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 10, 2017 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 June 8, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 17, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 8, 2017, effective July 17, 2017 and therefore remedies outlined in our letter to you dated June 26, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Licensing and Certification Program

Health Regulation Division

Aune Peterson -

Minnesota Department of Health

P.O. Box 64900

St. Paul, MN 55164-0900 anne.peterson@state.mn.us

Telephone #: 651-201-4206 Fax #: 651-215-9697



Electronically delivered

July 25, 2017

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

Re: Reinspection Results - Project Number S5588028

Dear Mr. Kelly:

On July 20, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 8, 2017, with orders received by you on June 27, 2017.

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.

Please feel free to call me with any questions.

Sincerely,

Licensing and Certification Program

Health Regulation Division

Aune Retension

Minnesota Department of Health

P.O. Box 64900

St. Paul, MN 55164-0900

anne.peterson@state.mn.us

Telephone #: 651-201-4206 Fax #: 651-215-9697

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: P04Q

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART I -	TO BE COMPI	LETED BY 1	THE STA	TE SURVEY AGENCY	Facility ID: 00444		
MEDICARE/MEDICAID PROVID     (L1) 245588	DER NO.	3. NAME AND AI (L3) <b>ST WILLIA</b>				4. TYPE OF ACTION: <u>2 (</u> L8)  1. Initial 2. Recertification		
2.STATE VENDOR OR MEDICAID	NO.	(L4) 212 WEST S	SOO STREET	C, BOX 30		3. Termination 4. CHOW		
(L2) <b>887342900</b>		(L5) PARKERS I	PRAIRIE, MN	J .	(L6) <b>56361</b>	5. Validation 6. Complaint 7. On-Site Visit 9. Other		
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEO 05 HHA	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY <b>06/</b> 0	<b>08/2017</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/III	15 ASC	FISCAL YEAR ENDING DATE: (L35)		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	06/30		
11LTC PERIOD OF CERTIFICATION	ON	10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complia	ance With		And/Or Approved Waivers Of	The Following Requirements:		
To (b):			equirements		2. Technical Personnel	6. Scope of Services Limit		
		1	e Based On:		3. 24 Hour RN	7. Medical Director		
12.Total Facility Beds	<b>53</b> (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	NF) 8. Patient Room Size		
13.Total Certified Beds	<b>53</b> (L17)	X B. Not in Con	nnliance with Pro	gram	5. Life Safety Code	9. Beds/Room		
15.176tai Continua Boas			and/or Applied	_	* Code: <b>B*</b>	(L12)		
14. LTC CERTIFIED BED BREAKD	OWN	l			15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
53								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date:			18. STATE SURVEY AGENCY			
Beth Nowling, HFE N	EII		07/10/2017	(L19)	Mark Meath,	Enforcement Specialist 08/03/2017 (L20		
PA	ART II - TO BE	COMPLETED I	BY HCFA R	EGIONAI	L OFFICE OR SINGLE S	STATE AGENCY		
19. DETERMINATION OF ELIGIBI	ILITY		IPLIANCE WIT	H CIVIL	21. 1. Statement of Financial Solvency (HCFA-2572)			
X 1. Facility is Eligible to	Participate	RIGI	HTS ACT:		<ol> <li>Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>Both of the Above :</li> </ol>			
2. Facility is not Eligib	-							
	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREE	MENT	26. TERMINATION ACTION	: (L30)		
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE.	VOLUNTARY 00	<u>INVOLUNTARY</u>		
12/01/1991					01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	ement 06-Fail to Meet Agreement		
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER		
		n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
	•		(L44)			00-Active		
(L27)	B. Rescind St	uspension Date:						
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	N OF APPROVA	L DATE				
				-	DEMEDIANT AND A STATE OF THE ST	DOVAL		
	(L32)			(L33)	DETERMINATION APP	KUVAL		



Electronically delivered June 26, 2017

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

RE: Project Number S5588028

Dear Mr. Kelly:

On June 8, 2017, 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 electronically delivered CMS-2567, whereby corrections are required.

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

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

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

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

<u>Remedies</u> - 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;

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

## <u>Informal Dispute Resolution</u> - 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
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us

Phone: (218) 332-5140 Fax: (218) 332-5196

### OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 18, 2017, 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 July 18, 2017 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.

St Williams Living Center June 26, 2017 Page 4

#### 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 September 8, 2017 (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

St Williams Living Center June 26, 2017 Page 5

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 December 8, 2017 (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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc</a> 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:

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012 Fax: (651) 215-0525

St Williams Living Center June 26, 2017 Page 6

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

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

Phone: (651) 201-4118 Fax: (651) 215-9697

PRINTED: 07/10/2017 FORM APPROVED OMB NO. 0938-0391

-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG			(X3) DATE SURVEY COMPLETED	
		245588	B. WING			06/	08/2017	
	PROVIDER OR SUPPLIER	R		212	EET ADDRESS, CITY, STATE, ZIP CODE WEST SOO STREET, BOX 30 RKERS PRAIRIE, MN 56361			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE .	(X5) COMPLETION DATE	
F 000	INITIAL COMMENT  The facility's plan of as your allegation of Department's accelenrolled in ePOC, yat the bottom of the form. Your electron be used as verificated Upon receipt of an on-site revisit of your validate that substate regulations has been your verification.  483.10(e)(1), 483.1 FROM PHYSICAL  §483.10(e) Respect The resident has a and dignity, includint §483.10(e)(1) The physical or chemical purposes of discipling required to treat the consistent with §483.12(a)(2).  42 CFR §483.12, 4 The resident has the neglect, misappropand exploitation as includes but is not least the consistent with suppose the propagation of the prop	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance.  acceptable electronic POC, an aur facility may be conducted to antial compliance with the en attained in accordance with 2(a)(2) RIGHT TO BE FREE RESTRAINTS  It and Dignity.  right to be treated with respecting: right to be free from any all restraints imposed for the or convenience, and not the resident's medical symptoms, as 3.12(a)(2)  the right to be free from abuse, riation of resident property, defined in this subpart. This imited to freedom from	F 0			RIATE	7/17/17	
ABORATORY	' DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE	

Electronically Signed 07/03/2017

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		SURVEY PLETED
		245588	B. WING		06/0	08/2017
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361	00/1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 221	or chemical restrain discipline or conver required to treat the symptoms. When indicated, the facilitial alternative for the ledocument ongoing restraints. This REQUIREMED by:  Based on observareview the facility faself-releasing alarm staff of attempted vas a physical restraint reviewed for restraint reviewed for restraint Findings include:  Review of R51's ar (MDS) dated 4/19/1 diagnoses which in The MDS further id cognitive impairme assistance with all except for eating. The physical restraints.  R51's Care Area As 4/21/17, identified in pain and restricted anticipate her need assistance with AD the use of a SRAB R51'S care plan print in the symptoms.	resident is free from physical nts imposed for purposes of nience and that are not e resident's medical the use of restraints is ty must use the least restrictive east amount of time and re-evaluation of the need for NT is not met as evidenced tion, interview and document ailed to ensure the use of a nibelt (SRAB), (which alerted wheelchair exits) was not used with the for 1 of 1 residents (R51) ints.  Innual Minimum Data Set 17, identified R51 had cluded dementia and arthritis. Intentified R51 had severe not and required extensive activities of daily living (ADL's) The MDS indicated R51 had no resessment (CAA) dated R51 had dementia, arthritis, mobility, and staff were to its and provide extensive L's. The CAA failed to identify	F 221	For resident (R51) a Self Release Belt (SRAB) elimination/reduction i completed. If resident (R51) is no to unable to remove the SRAB by he by July 3, 2017, it will be assessed restraint.  All residents with an SRAB will have reduction/elimination completed if applicable at least quarterly. Nurse assure weekly that resident can rete the SRAB per self. If resident is not to release belt per self, it will be assess as a restraint per facility policy. The Release Alarm Belt Policy, Alarm Reduction Policy, Restraint Assess and Self Release Alarm Belt Assess were reviewed and updated prior to 2017.  Nursing staff will be educated at numeeting July 12, 2017 and all other will be educated by July 17, 2017. The medical director will be updated on policy changes on July 11, 2017. The Director of Nursing will complete readulits of all residents that have SR	e will move of able sessed e Self ment, sment o July 3, arses staff The final the andom	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		E SURVEY IPLETED
		245588	B. WING _		06/	08/2017
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP C 212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 221	required extensive staff were to anticip R51's safety and con R51 would release she had to use the transfer into bed. Tangs it in a regular and activities without or release the SRA the dining room que Review of R51's Sedated 4/13/17, identified arthritis. The arthritis. The arthritis. The arthritis. The arthritis. The arthritis. The arthritis are ducated was taught how the to release it on here. On 6/05/17, from 5 seated in the dining table for the supperfull of residents as provided assistance tables. R51 wore are a white plastic hool closed around R51 wheelchair. R51 saresidents and ate hoof 107/17, at 1:50 wheelchair in front wore a blue Velcroplastic hook and lo around R51's waisi R51's hands were shook in a tremor as	care plan further identified R51 assistance with ADL's, and bate her needs to maintain omfort. The care plan indicated her SRAB to alert staff when bathroom or wanted to the care plan indicated R51 dining room chair at meals ut an alarm, and it was ok not B at meals due to R51 leaving ickly and was a fall risk.  Telf Release Belt Assessment attified R51 was disoriented and ssessment further identified on the reason for the SRAB, as SRAB worked and was able	F 22	ensure policy is being follow will be discussed at QA commeetings quarterly to ensure the second sec	nmittee	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  UNG			E SURVEY IPLETED
		245588	B. WING	- <u></u>		06/	08/2017
	PROVIDER OR SUPPLIER	₹		STREET ADDRESS, CITY, STATE, ZIP 212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 5636			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD HE APPROPR	BE	(X5) COMPLETION DATE
F 221	was confused and with her ADL's. She self-release alarm is and stated she thou herself.  On 6/7/17, at 1:52 pwith surveyor in from asked R51 several SRAB off while she it by opening her ar not attempt to remover the words "tapiece of white paper face for her to read release the SRAB areleased R51's SRAB and continue releasing the SRAB and talked under her on 6/08/17, at 9:37 confused and required R51 had used the SR51 had used the SRAB and sand talked under her sand talked used the SR51 had us	required extensive assistance estated R51 had worn the selt (SRAB) for a year or 2, aght R51 could release the belt on. NA-C approached R51 hat of the nurses station. NA-C times out loud to take her demonstrated how to release ms in a quick motion. R51 did ove the SRAB. NA-C then ke off your seat belt" on a r and put up close to R51's. R51 did not attempt to after written request. NA-C AB and demonstrated how to or R51. NA-C reapplied R51's ed to act out the action of B. R51 made no attempt to and just smiled, belly laughed	F 2	221			
	use the bathroom ribeen a couple weel release the SRAB conly removed it for to bed or when they She stated R51 uses she's in her wheelc	on her own when she had to ght away, and stated it had as since she observed R51 on her own. She stated staff meals, at night when she went or put her in a regular chair. The stated the SRAB all the time when thair, and R51 mostly liked to cility in her wheelchair.					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		E SURVEY MPLETED
		245588	B. WING		06	/08/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361		00/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 221	cognitively impaire with ADL's. She st R51 had used the R51 could release stated she had new SRAB on her own. when they take her dining room.  On 6/8/17, at 9:56 confused and requirer ADL's. She stated SRAB for about a yealf-transfers. She release the belt by the bathroom immore thought the last time the SRAB on her of ago. She stated the mealtimes and whe chair.  On 6/8/17, at 10:12 (LPN)-B stated R5 assistance with all R51 had the SRAB stated it was to prefer own. She stated was last able to rel She stated they rei	age 4 3 a.m. NA-I stated R51 was d and required staff assistance ated she wasn't sure how long SRAB. She stated she thought the SRAB but she did not, and ver seen R51 release the She stated staff released it to the bathroom and in the sa.m. NA-J stated R51 was ired extensive assistance with ted she thought R51 had the year to prevent unsafe stated R51 probably could not herself, unless she had to use ediately. She stated she he she observed R51 release with was about a couple months as SRAB was released at en R51 was is in a regular.  2 a.m. licensed practical nurse 1 was confused and required cares. She stated she thought of the stated she hought of the state	F 22	,		
	be able to remove they could remove SRAB was applied the SRAB off it was	residents at the facility had to the SRAB and demonstrate it on their own before the . She stated if R51 couldn't get is a restraint.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION IG		MPLETED
		245588	B. WING _		06	/08/2017
_	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CO 212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 221	assistance with AD the SRAB since 7/1 injury. She stated sunable to release the stated she was not since R51 was able own. She stated the as they felt the SR/a physical restraint R51's SRAB in the them to transfer he chair and when R5 On 6/8/17, at 11:10 interview with NM-/R51 could not release and stated she felt SRAB in the past.  NM-B confirmed RSRAB was completed and stated if R51 was able to result of the SRAB was completed and stated if R51 was able to result of the stated if R51 was able to result of the SRAB on her own it would be confirmed the SRAB on her own it stated the facility diphysical restraint for R51 could release R51 may not be has SRAB on command DON stated if R51 SRAB on her own,	Infused and required extensive L's. She stated R51 has had 10/14 after she had a fall with he was not aware R51 was ne SRAB on her own, and sure how long it had been to release the SRAB on her ey had never tried a reduction AB was a safety device and not. She stated the staff released dining room if she would allow r into a regular dining room	F 22	11		

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY DMPLETED
	245588	B. WING		6/08/2017
	3	2	STREET ADDRESS, CITY, STATE, ZIP CODE 212 WEST SOO STREET, BOX 30	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Care Plans dated 6 would have a comp problems/needs ide restraints and would to achieve and/or mphysical, mental an 483.21(b)(3)(ii) SEPPERSONS/PER CA(b)(3) Comprehension The services provides	/2016, identified each resident rehensive assessment with rentified which included physical directive the care necessary raintain their highest practical dipsychological well-being. RVICES BY QUALIFIED ARE PLAN ive Care Plans led or arranged by the facility,	F 221		7/17/17
accordance with eacare. This REQUIREMENT by: Based on observate review, the facility for ordered use of therestockings (designed swelling) as identified plan of care for 1 of Findings include: R66's care plan data impaired mobility, warthritis pain. The cowas independent where high/thigh high day. The care plan stockings were to be H.S. (hour of sleep)	ch resident's written plan of NT is not met as evidenced ions, interviews and document ailed to follow physician apeutic compression of the help relieve aches and ed on the resident's written of 3 residents (R66) reviewed.  The second of the test of the second of the help relieve aches and ed on the resident's written of 3 residents (R66) reviewed.  The second of		Treatment Administration Record (TAR) assure resident has his compression stockings applied on and off per care plan. If resident, the nurse will chart his refusal in resident's record after educating on risks/benefits of compressions stockings.  All residents who have compression stockings ordered have had nurse follow-up added to their TAR to assure that residents have their compression stockings on/off per care plan. Nurse with chart refusals in resident's record after educating on risks/benefits of compressions stockings.	g g
,	PROVIDER OR SUPPLIER  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS  Continued From pa Care Plans dated 6, would have a comp problems/needs ide restraints and would to achieve and/or m physical, mental and 483.21(b)(3)(ii) SEF PERSONS/PER CA  (b)(3) Comprehensi The services provid as outlined by the c must-  (ii) Be provided by c accordance with ea care. This REQUIREMEN by: Based on observat review, the facility fa ordered use of thera stockings (designed swelling) as identifie plan of care for 1 of Findings include:  R66's care plan dat impaired mobility, w arthritis pain. The ca was independent w knee high/thigh high day. The care plan stockings were to b H.S. (hour of sleep)	PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 6  Care Plans dated 6/2016, identified each resident would have a comprehensive assessment with problems/needs identified which included physical restraints and would receive the care necessary to achieve and/or maintain their highest practical physical, mental and psychological well-being.  483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-  (ii) Be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observations, interviews and document review, the facility failed to follow physician ordered use of therapeutic compression stockings (designed to help relieve aches and swelling) as identified on the resident's written plan of care for 1 of 3 residents (R66) reviewed.	A. BUILDING  245588  B. WING  PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 6  Care Plans dated 6/2016, identified each resident would have a comprehensive assessment with problems/needs identified which included physical restraints and would receive the care necessary to achieve and/or maintain their highest practical physical, mental and psychological well-being.  483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-  (ii) Be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observations, interviews and document review, the facility failed to follow physician ordered use of therapeutic compression stockings (designed to help relieve aches and swelling) as identified on the resident's written plan of care for 1 of 3 residents (R66) reviewed.  Findings include:  R66's care plan dated 6/6/17, identified R66 had impaired mobility, weakness and potential for arthritis pain. The care plan further identified R66 was independent with dressing and was to utilize knee high/thigh high compression stockings every day. The care plan indicated R66's compression stockings were to be on in the morning and off at H.S. (hour of sleep).	PROVIDER OR SUPPLIER  245588  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 212 WEST SOO STREET, BOX 30  PARKERS PRAIRIE, MN 56361  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 6  Care Plans dated 6/2016, identified each resident would have a comprehensive assessment with problems/needs identified which included physical restraints and would receive the care necessary to achieve and/or maintain their highest practical physical, mental and psychological well-being. 483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-  (ii) Be provided by qualified persons in accordance with each resident's written plan of care.  (iii) Be provided by qualified to follow physician ordered use of therapeutic compression stockings (selsigned to help relieve aches and swelling) as identified on the resident's written plan of care for 1 of 3 residents (R66) reviewed.  Findings include:  R66's care plan dated 6/6/17, identified R66 had impaired mobility, weakness and potential for arthritis pain. The care plan further identified R66 was independent with dressing and was to utilize knee high/thigh high compression stockings were to be on in the morning and off at H.S. (hour of sleep).

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G		E SURVEY PLETED
		245588	B. WING		06/	08/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 282	sheet dated 6/8/17 knee high/thigh hig every morning and On 6/05/17, at 4:33 room in his wheeld floor. R66's ankles and had significant circumference of belastic band on the ended. R66 was not stockings on either assistance to apply and staff were supcompression sock off at night before compression sock swelling and pain it some staff were all them on and take the had laid out his floor in his doorwal would get the hint compression sock legs.	r, identified R66 was to use the compression stockings, on a off at bedtime.  By p.m. R66 was seated in his chair, both feet rested on the up to his calves were swollen to indentations around the both calves from where the etop of his regular white socks of wearing compression roleg. He stated he required by the compression stockings posed to put on his in the morning and take them he went to bed. R66 stated the swere ordered to reduce the his legs. He stated he felt cosent minded and forgot to put them off. He stated in the past compression socks on the yto get staff's attention so they to put them on. He stated the skept the swelling down in his	F 28	meeting July 12, 2017 and a will be educated by July 17, medical director will be updated policy changes on July 11, 2 Director of Nursing will compaudits of all residents that has compression stockings to enbeing followed. Results will at QA committee meetings of ensure compliance.	2017. The sted on final 017. The olete random ave usure policy is be discussed	
	seated in his wheele on both feet and we socks to either leg around his mid call top of his socks we wear these socks and his legs swelled compression sock supposed to put the day and indicated or remove his composed to put the day and indicated or remove his composed to put the day and indicated or remove his composed to put the day and indicated or remove his composed to put the day and indicated or remove his composed to put the day and indicated or remove his composed to put the day and indicated the day and	5 p.m. R66 was in his room elchair with regular black socks as not wearing compression. R66 had deep indentations wes where the elastic from the ere. R66 stated he should not because they were too tight, and up quickly without the son. He stated staff were e compression socks on every staff did not consistently apply a pression socks. R66 stated he ompression socks for 2 days				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245588	B. WING _		06	/08/2017
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP COL 212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 282	applying the compression socks. She stated them on every day, refused. She stated usually let the nurs convince him to put thought R66 always. On 6/06/17, at 3:22 needed help with his stated either the nurs convince him to put thought R66 always. On 6/06/17, at 3:22 needed help with his tated either the nurs compression socks wear them every direfuse to wear the willing to let him put on. He stated R66 compression socks compression socks. On 6/6/17, at 3:32 stated R66 requires applying and remor RN-A indicated R66 the compression so a pattern of refusing physician of any results.	not offered to assist with ression stockings. He stated his compression socks they take them off and then in the ere uncomfortable. He stated have staff he could can rely on not rely on. He stated he did hin because he felt that made do not want to use his call light	F 28	32		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY PLETED
		245588	B. WING			06/	08/2017
	PROVIDER OR SUPPLIER			212	WEST SOO STREET, BOX 30 RKERS PRAIRIE, MN 56361	,	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	stated she expected every morning and stated R66 had all day to day.  On 6/6/17, at 3:35 entered R66's roomerecliner with his feand wore regular to had both socks put and was not wear in either leg. RN-A compression sock should have put the R66, "Why aren't ysocks?" R66 replies want to complain to Compression sock and cooperative word compression sock responsible to appression sock responsion sock responsible to appression sock re	age 9 ed the NA's to put them on I take them off every night. She ot of edema, which varied from p.m. RN-A and surveyor m. R66 was seated in his et elevated on the foot rests plack socks on both feet. R66 shed down around his ankles ing his compression socks to prefirmed R66 did not have his is on either leg, and stated staff them on this morning. RN asked you wearing your compression to the staff forgot and I did not because it aggravated people.  6 a.m. NA-G stated R66 ewith applying his is son. She stated R66 was thankful then staff helped put his is on. She stated the NA's were also R66 compression socks and they put them on and took them for got up on his own in the lid have assistance with the ression socks before breakfast. Swelling in his legs was better this compression socks, and y helped to reduce R66's  28 a.m. nurse manager (NM-A) did a current physician's order for sor chronic swelling in his legs stated she expected staff to ression stockings every them off at bedtime as directed	F 2	282			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245588	B. WING		06.	/08/2017	
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 309 SS=D	with the application compression socks documentation of F stated she question documentation, as wear them more the revealed.  On 6/08/17, at 1:20 stated the compression socks treatment for R66 to reduce edema in his expected staff to appected staff to appected staff to appected out consists specific needs.  483.24, 483.25(k)(I) FOR HIGHEST WE 483.24 Quality of life is a functional provided services to all care a residents. Each refacility must provide services to attain or practicable physical well-being, consists comprehensive assistant applies to all treatments.	ne stated R66 required help and removal of his and red the accuracy of the she thought he refused to an the documentation  p.m. director of nurses (DON) sion socks were a necessary of improve circulation and siegs. The DON stated she oply and remove R66's as directed by the care plan.  Typolicy, Assessments and and and and and and resident and resident's and resident's and resident's and resident and resident must receive and the resident must receive and the resident and psychosocial and with the resident's resident's resident and plan of care.		282		7/17/17	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245588	B. WING			06/0	)8/2017
	PROVIDER OR SUPPLIER	3		2	TREET ADDRESS, CITY, STATE, ZIP CODE 12 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 309	assessment of a re that residents recei accordance with propractice, the compressed plan, and the rebut not limited to the (k) Pain Manageme The facility must enprovided to resident consistent with profithe comprehensive and the residents' (I) Dialysis. The facility services, consistent of practice, the comprehenses. This REQUIREMENT by:  Based on observative review, the facility for the comprehensive and the residents who requires the residents where the resi	sident, the facility must ensure we treatment and care in ofessional standards of ehensive person-centered residents' choices, including e following:  ent. sure that pain management is ts who require such services, essional standards of practice, person-centered care plan, goals and preferences.  cility must ensure that ire dialysis receive such the with professional standards aprehensive person-centered residents' goals and  NT is not met as evidenced cions, interviews and document ailed to apply therapeutic	F3	809	Resident R66 now has nurse follow Treatment Administration Record (T	AR) to	
	swelling and aching	ngs (designed to help relieve g) as ordered by the physician (R66) reviewed for localized			assure resident has his compression stockings applied on and off per car plan. If resident, the nurse will chart refusal in resident's record after edu on risks/benefits of compressions stockings.	e t his	
	5/16/17, revealed a knee high gradient placed on in the mo R66's admission M 3/19/17 identified R	rrent physician orders dated n order started 3/12/17, for pressure stockings to be brning and off in the evening.  inimum Data Set (MDS) dated 66 had diagnoses which ain, weakness and localized			All residents who have compression stockings ordered have had nurse follow-up added to their TAR to assuthat residents have their compression stockings on/off per care plan. Nurse chart refusals in resident's record af educating on risks/benefits of compressions stockings.	ure on se will	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
		245588	B. WING		06/0	08/2017
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	cognitively intact ar activities of daily live. Review of R66's Cadated 3/20/17, iden limited range of mobalance, arthritis pwith changing cognindicated R66 required compress. R66's care plan daimpaired mobility, varthritis pain. The cwas independent with knee high/thigh high day. The care plan stockings were to be H.S. (hour of sleep Review of the nursi sheet dated 6/8/17 knee high/thigh high every morning and Review of R66's mand treatment admit to 6/8/2017 lacked compression stock. On 6/05/17, at 4:33 room in his wheeled floor. R66's ankles and had significant circumference of be elastic band on the	urther identified R66 was and was independent with all ing (ADL's) except toileting.  The Area Assessment (CAA) atified R66 had weakness, ation, poor coordination and ain and cognitive impairment aitive status. The CAA further ired physical assistance with to identify R66 had edema or ion socks.  The CAA further identified R66 had weakness and potential for eare plan further identified R66 with dressing and was to utilize the compression stockings every indicated R66's compression to on in the morning and off at the compression stockings, on off at bedtime.  The CAA further identified R66 had weakness and potential for eare plan further identified R66 was to utilize the compression stockings every indicated R66's compression off at bedtime.  The CAA further identified R66 had weakness and potential for eare plan further identified R66 was to utilize the compression stockings and off at bedtime.	F 309	Nursing staff will be educated at meeting July 12, 2017 and all oth will be educated by July 17, 2017 medical director will be updated of policy changes on July 11, 2017. Director of Nursing will complete audits of all residents that have compression stockings to ensure being followed. Results will be di at QA committee meetings quarte ensure compliance.	er staff . The on final The random policy is scussed	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245588	B. WING		06/	/08/2017	
	PROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE 212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 309	assistance to apply and staff were supp compression socks off at night before he compression socks swelling and pain in some staff were about them on and take the had laid out his offloor in his doorway would get the hint to compression socks legs.  On 6/06/17, at 2:35 seated in his wheeled on both feet and was socks to either legaround his mid calve top of his socks we wear these socks be and his legs swelled compression socks supposed to put the day and indicated sor remove his comphad not worn his composed to put the day and indicated sor remove his compression socks supposed to put the day and indicated sor remove his compression socks supposed to put the day and indicated sor remove his compression socks supposed to put the day and indicated sor remove his compression socks supposed to put the day and indicated sor remove his compression socks supposed to put the day and indicated sor remove his compression socks supposed to put the day and indicated sor remove his compression socks supposed to put the day and indicated sor remove his compression socks supposed to put the day and indicated sor remove his compression socks supposed to put the day and indicated sor remove his compression socks supposed to put the day and indicated sor remove his compression socks supposed to put the day and indicated sor remove his compression socks supposed to put the day and indicated sor remove his compression socks supposed to put the day and indicated sor remove his compression socks supposed to put the day and indicated sor remove his compression socks supposed to put the day and indicated sor remove his compression socks supposed to put the day and indicated sor remove his compression socks supposed to put the day and indicated sor remove his compression socks supposed to put the day and indicated sor remove his compression socks supposed to put the day and indicated sor remove his compression socks supposed to put the day and indicated sor remove his compression socks supposed to put the day and indicated sor remove	leg. He stated he required the compression stockings losed to put on his in the morning and take them e went to bed. R66 stated the were ordered to reduce his legs. He stated he felt sent minded and forgot to put nem off. He stated in the past compression socks on the to get staff's attention so they of put them on. He stated the kept the swelling down in his p.m. R66 was in his room chair with regular black socks as not wearing compression R66 had deep indentations les where the elastic from the re. R66 stated he should not ecause they were too tight, dup quickly without the on. He stated staff were ecompression socks on every taff did not consistently apply pression socks. R66 stated he impression socks for 2 days not offered to assist with ession stockings. He stated is compression socks they of take them off and then in the ere uncomfortable. He stated we staff he could can rely on not rely on. He stated he did n because he felt that made if not want to use his call light	F3	09			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		245588	B. WING		06/	08/2017
	PROVIDER OR SUPPLIER	₹		STREET ADDRESS, CITY, STATE, ZIP CODE 212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDENCY)	D BE	(X5) COMPLETION DATE
F 309	required extensive remove his compre NA's were responsithem off every day.  On 6/06/17, at 3:14 required assistance socks. She stated them on every day, refused. She stated usually let the nurse convince him to put thought R66 always  On 6/06/17, at 3:22 needed help with his stated either the nurse compression socks wear them every darefuse to wear the willing to let him put on. He stated R66's compression socks compression socks compression socks a pattern of refusing physician of any refusited she expected every morning and	ge 14 p.m. NA-F confirmed R66 assistance to apply and ssion socks. She stated the ble to put them on and take  p.m. NA-E stated R66 to apply his compression he staff usually tried to put and stated some days R66 when R66 refused they would know and she could usually them on. She stated she had edema in his legs.  p.m. NA-K stated he felt R66 s compression socks. He rse or the NA's applied R66's and R66 was supposed to by. He stated R66 did not compression socks and was the compression stockings selegs were huge without the and R66 had told him the helped a lot with his swelling.  p.m. registered nurse (RN)-A d staff's assistance with ring his compression socks. Soccasionally refused to wear and they had not notified his usals. She confirmed R66's e compression socks and d the NA's to put them on take them off every night. She at of edema, which varied from	F3	09		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245588	B. WING		<del></del>	06/0	08/2017
	PROVIDER OR SUPPLIER	R		2	TREET ADDRESS, CITY, STATE, ZIP CODE 112 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	entered R66's room recliner with his fee and wore regular by had both socks pus and was not wearing either leg. RN-A concompression socks should have put the R66, "Why aren't you socks?" R66 replies want to complain by socks?" R66 replies want to complain by compression socks and cooperative who compression socks and cooperative who compression socks and cooperative who compression socks responsible to apply document when the off. She stated R66's sha slong as he wore stated she felt they swelling.  On 6/08/17, at 10:2 confirmed R66 had compression socks from arthritis. She sapply R66's compression socks from arthritis. She sapply R66's compression socks from arthritis. She sapply R66's compression socks from socks documentation of F	o.m. RN-A and surveyor  n. R66 was seated in his t elevated on the foot rests ack socks on both feet. R66 shed down around his ankles g his compression socks to infirmed R66 did not have his on either leg, and stated staff em on this morning. RN asked by wearing your compression d the staff forgot and I did not because it aggravated people.  a.m. NA-G stated R66	F3	;09			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245588	B. WING			06/	08/2017
	PROVIDER OR SUPPLIER	R		2	STREET ADDRESS, CITY, STATE, ZIP CODE 212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	wear them more the revealed.  On 6/08/2017, at 1 interview NM-A stat for applying R66's of documented refusal if the documentation multiple days she with physician. She state updated the physician stated there was not benefit education for wear the compression socks for R66's pain and state of the state	she thought he refused to an the documentation  :04 p.m. during follow-up ted the NA's were responsible compression socks and als in the computer. She stated in identified several refusals for would address it with the ed she had not personally it is in with any refusals, and of the documentation of risk and or R66 when he refused to ion socks. She stated the swere a necessary treatment	F3	609	,		
	socks from 3/12/17 3/12/17-3/31/17, Reapplied every morn with the exception of 5 days.  4/1/17-4/30/17, Reapplied every morn with the exception of 1 day.  5/1/17-5/31/17, Reapplied every morn with the exception of 1 day and 1 refusal  6/1/17-6/8/17, Reapplied every morn with the exception of 1 day and 1 refusal	to 6/8/17 revealed: 66 had his compression socks ing and removed every night of 66 had his compression socks ing and removed every night of 66 had his compression socks ing and removed every night of					
	applied every morn with the exception of						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245588	B. WING _		06/	08/2017	
	ROVIDER OR SUPPLIER	٦		STREET ADDRESS, CITY, STATE, ZIP CODE 212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309	indicated they appli on 6/5/17 and 6/6/1 without them on.  On 6/08/17, at 1:20 stated the compress treatment for R66 to reduce edema in his expected staff to appression socks.  On 6/08/17, at 1:45 interview, nurse pracompression stocki for R66's bilateral (I stated she would exphysicians order for On 6/08/17, at 2:20 interview, R66's physicians order for ware R66 was opposite to facility to follow compression socks.  Review of the facility to facility to follow compression socks.	entation also identified staff ed R66's compression socks 7 despite observation of R66  p.m. director of nurses (DON) sion socks were a necessary of improve circulation and selegs. The DON stated she oply and remove R66's as directed by the care plan.  p.m. during telephone actitioner (NP) stated the ngs were specifically ordered eft and right) edema. She expect the facility to follow the refer the compression stockings  p.m. during telephone specifically ordered eft and right) edema. She expect the facility to follow the refer the compression stockings  p.m. during telephone specifically ordered eft and right edema. She expect the facility to follow the refer the compression stockings  p.m. during telephone specifically ordered eft and right edema stated the compression socks welling. He stated he was not consed to wearing the consederation.	F 30	9			
F 312 SS=D	Care Plans dated 6 would ensure care carried out consiste specific needs.	/2016, identified the facility plans were appropriate and ently to meet each resident's	F 31	2		7/17/17	
		no is unable to carry out ing receives the necessary					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		SURVEY PLETED
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	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361	1 00/0	30,2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	services to maintai personal and oral har This REQUIREMED by: Based on observareview the facility faservices related to of 1 residents (R51 facial hair.  Findings include: Review of R51's ar (MDS) dated 4/19/diagnoses which in pain. The MDS furt cognitive impairme assistance with all except for eating.  R51's Care Area As 4/21/17, identified fand restricted mob staff were to anticipextensive assistance.  Review of R51's caidentified R51 requisited R51	n good nutrition, grooming, and hygiene.  NT is not met as evidenced tion, interview and document ailed to provide grooming the removal of facial hair for 1) observed to have significant in the interview and document ailed to provide grooming the removal of facial hair for 1) observed to have significant in the interview and in the interview and required R51 had severe activities of daily living (ADLs) assessment (CAA) dated R51 had dementia, arthritis and her identified on the interview and provide the with R51's needs and provide the with R51's ADLs.  The plan dated 10/29/14, ired extensive assistant of 1 and R51 was to be neat and in her wheelchair. R51 was	F 312	Resident R51's daughter was calle electric shaver was brought to facil family for resident's use. The residents was shaved by staff on June 10, 20.  All residents were asked if they was be shaved. Any residents that did want to be shaved had this informated added to their care plan/Kardex. They was wanted to be shaved were austed if they had their own shaver, if family was contacted to bring in a story them.  The Shaving Policy was reviewed a updated on June 21, 2017. Social Services will ask upon admission if resident wants to be shaved. If resident wants to be shaved, the information will be added to their caplan. If the resident does want to be shaved, an electric razor will be broby resident or family.  Nursing staff will be educated at numeeting July 12, 2017 and all other will be educated by July 17, 2017. The medical director will be updated on policy changes on July 11, 2017.	ity by lent 017. Inted to not tion hose dited to not shaver and lident are be bught in lerses staff. The final the	
	and light brown fuz her nose and down had a few longer, o mouth, several sho	ficant facial hair. R51 had gray zy hair which went from under the sides of her mouth. R51 oarse hairs near corners of orter gray hairs under chin, a hairs under her chin and		Director of Nursing will complete ra audits of all residents for shaving of to ensure policy is being followed. Results will be discussed at QA committee meetings quarterly to en compliance.	hoices	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245588	B. WING			06/0	08/2017
	PROVIDER OR SUPPLIER	R		2	TREET ADDRESS, CITY, STATE, ZIP CODE 12 WEST SOO STREET, BOX 30 ARKERS PRAIRIE, MN 56361		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	nairs under bottom On 6/06/17, at 2:11 self-propelling dow and continued to h On 6/07/17, at 12:3 the dining room se continued to have se On 6/07/17, at 12:3 (NA)-G stated R51 required extensive the usual facility pr were shaved as ne weeks. She stated in their bedroom di bath day today and shaved today if she On 6/07/17, at 12:1 (LPN)-A stated R51 required extensive stated the usual factor residents were sha She stated R51 sh with her bath. On 6/07/17, at 1:50 confused and requ ADLs. NA-C stated morning cares that unaware R51 had is should be shaved of hair removal. NA-C and that R51 did ne room. NA-C stated	parse, light brown and gray lip in the crease of her chin.  p.m. R51 was observed in the hallway in her wheelchair ave significant facial hair.  B9 p.m. R51 was observed in ated in a regular chair and significant facial hair.  O0 p.m. nursing assistant was very confused and assist with ADLs. NA-G stated actice was female residents reded which was about every 3 residents had their own razors rawer. She stated it was R51's IR51 should have been	F3	312			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		245588	B. WING _		06/	08/2017
	PROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE 212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 312	Continued From pa today.	ge 20	F 31	2		
	provided R51 a bath doesn't keep person sanitary reasons. S	B p.m. NA-D stated she h today, and stated she hal razors in the tub room for he stated the NA who cared a used R51's personal razor is morning.				
	confirmed R51 had stated she wasn't s last. She stated she	8 a.m. nurse manager (NM-A) never had her own razor, and ure when R51 was shaved expected staff to remove hey notice it and expected all ce.				
F 323 SS=D	living (ADLs) was re not have a specific	prooming and activities of daily equested. DON stated they did policy related to these.  1)-(3) FREE OF ACCIDENT VISION/DEVICES	F 32	3		7/17/17
	(d) Accidents. The facility must en	sure that -				
		vironment remains as free rds as is possible; and				
		eceives adequate supervision ices to prevent accidents.				
	appropriate alternate bed rail. If a bed or must ensure corrections	e facility must attempt to use cives prior to installing a side or side rail is used, the facility t installation, use, and d rails, including but not limited nents.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION (	(X3) DATE SURVEY COMPLETED	
		245588	B. WING		06/08/2017	
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361	03.03.20.1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 323	Continued From pa	age 21 dent for risk of entrapment	F 320	3		
	the resident or resi informed consent p (3) Ensure that the appropriate for the	s and benefits of bed rails with dent representative and obtain				
	by: Based on observa review the facility fa implementation of a	tion, interview and document ailed to ensure consistent a smoking apron to prevent idents (R28) reviewed who		Resident R28 had a smoking assessment completed on June 6, 2 The smoking apron was removed from the smoking apron was removed from the sessment. All residents were audited to determine smoked and no other residents smo	who	
	(MDS) dated 11/1/ moderate cognitive which included den obstructive pulmon anxiety. The MDS i extensive assistant (ADL's,) including a	nange Minimum Data Set 16, identified R28 had impairment and diagnoses nentia, epilepsy, chronic ary disease (COPD) and dentified R28 required ce with areas of daily living ambulation and locomotion. Identify whether R28 used		that point in time.  The smoking restrictions policy was updated June 20, 2017. The Assessments and Care Plans policy updated on June 21, 2017. An audiform was developed to assure all assessments and care plans are completed per the facility policy and resident needs.	was ting	
	R28 had severe co diagnoses which in COPD and anxiety continued to requir ADL's. The MDS di used tobacco produ	DS dated 4/19/17, identified gnitive impairment and had cluded dementia, epilepsy, The MDS identified R28 ed extensive assistance with d not identify whether R28 ucts.		Nursing staff will be educated at nur meeting July 12, 2017 and all other will be educated by July 17, 2017. The medical director will be updated on find policy changes on July 11, 2017. The Director of Nursing will complete rar audits of the to ensure that assessmand care plans are being completed the facility policy and resident needs	staff The Tinal Ti	

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245588	B. WING			06/	08/2017
NAME OF PROVIDER OR SUPPLIER  ST WILLIAMS LIVING CENTER				2	TREET ADDRESS, CITY, STATE, ZIP CODE 112 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From page 22 identified R28 had cognitive loss, smoked cigarettes daily and required physical assistance from facility staff with obtaining and lighting the cigarette. The smoking assessment identified R28 required one on one staff supervision when smoking. The assessment further identified R28 required the use of a smoking apron (apron made of fire retardant material worn to protect against burns) during smoking.		F3	323	Results will be discussed at QA committee meetings quarterly to er compliance.	nsure	
	was a current active identified various in safety which include smoking, staff to stematerials, light tobaresident's safety du	rised 1/26/17, identified R28 as smoker. The care plan tervention for R28's smoking ed; no oxygen use when ore, distribute R28's smoking acco products, staff to monitor ring smoking. R28's care pland stand inside the facility door, nile he smoked.					
	assistant (TMA)-A eand obtained a cigarequest. TMA-A was propelled her whee and out to the smol TMA-A passed by taprons hanging by foyer, however; did TMA-A handed R28 lighter for R28 to ligitating R28. R28 in cigarette, smoked, extinguished the cigareceptacle. Althoughated 11/3/16, iden	garette in the provided metal gh R28's smoking assessment tified the need for use of a 8 did not wear a smoking					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245588	B. WING		06	/08/2017	
NAME OF PROVIDER OR SUPPLIER  ST WILLIAMS LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP COE 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 PREFI TAG	PROVIDER'S PLAN OF CORR  (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 323	wheelchair outside director (AD)-A wh against the outside smoking patio. R26 on. R28 was seate smoking receptacl independently smoextinguished the comparison of 6/05/2017, at 1 required staff assist needed facility staff smoked. TMA-A in assessment and contravare R28 needed sit with R28 watch her while should sit with R28 watch her while should sit with her while should liwith her while she had poor short terms moke often. AD-Acigarette right after poor memory.  On 6/06/2017, at 1 (NA)-A indicated a to smoke. NA-A staff smoking apron was hung on the wall in would apply the smoking apply the smoking apply the smoking apply the smokens.	9:40 a.m. R28 was seated in a the facility with activities o was seated in a chair wall of the facility on the 3 did not have a smoking aproned in the wheelchair next to the with her back to AD-A. R28 oked, disposed of ashes and	F3	223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245588	B. WING			06/0	08/2017
NAME OF PROVIDER OR SUPPLIER  ST WILLIAMS LIVING CENTER				2	TREET ADDRESS, CITY, STATE, ZIP CODE 12 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 PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From pa the smoking apron burned.	age 24 was used so R28 would not	F 3	23			
	cigarette and lighter medication room. In the smoking mater outside, place a smocigarette and stay smoking. NA-B indused in case R28 c NA-B verified he/sh	2:02 p.m. NA-B indicated R28's er were locked in the NA-B indicated staff would get ials from a nurse, take R28 noking apron on R28, light the with R28 until she was finished icated the smoking apron was dropped ashes on herself. The had not seen R28 drop a f but had witnessed her drop					
	wheel chair on the white smoking apro and lap. Activity aid R28 as she indepe At 2:51 p.m. AA-A placed it on the hor assisted R28 into the short should be a second to the short should be a short short should be a short short short short short should be a short sho	-					
	nursing staff would sit with R28 while s smoking materials medication room, a placed on R28 so t	2:53 p.m. AA-A indicated find AA-A and request he/she she smoked. AA-A indicated were retrieved from the a smoking apron would be hat she would not burn herself en sit and visit until R28 is					
	was reviewed with	3:16 p.m. R28's medical record nurse manager (NM)-A. e most recent smoking					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
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	PREFIX TAG  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 323  Continued From page 25  assessment was completed on 11/3/16. NM-A verified the assessment noted R28 required the use of a smoking apron. NM-A confirmed R27's current care plan did not direct the use of a smoking apron. NM-A indicated the usual facil practice was for each resident care be provided as directed by the assessment identified a need such as a smoking apron the smoking apron would be expected to be utilized each time the resident smoked.  On 6/06/2017, at 3:42 P.M. the director of			STREET ADDRESS, CITY, STATE, ZIP CODE 212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361	·	
PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE
F 323	assessment was coverified the assessing a current care plan dismoking apron. No practice was for east directed by the aindicated when an asuch as a smoking would be expected resident smoked.  On 6/06/2017, at 3 nursing (DON) indice perform an initial smadmission and the status. The DON veassessments were system. With review DON verified R28's was completed in indicated being unacognition or physical assumed if the care discontinue the use assessment should DON further indicates smoking apron, tho required one.  On 6/06/2017, 4:03 responsible for discontinue the use assessment should DON further indicates smoking apron, tho required one.  On 6/06/2017, 4:03 responsible for discontinue the use assessment should DON further indicates smoking apron, tho required one.	ompleted on 11/3/16. NM-A ment noted R28 required the pron. NM-A confirmed R27's d not direct the use of a M-A indicated the usual facility ch resident care be provided assessment findings. NM-A assessment identified a need apron the smoking apron to be utilized each time the :42 P.M. the director of cted the facility protocol was to moking assessments upon a quarterly or with a change in	F3	323		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY MPLETED
		245588	B. WING		06/	/08/2017
	PROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CO 212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	document the findir notes and then to c NM-B verified neith progress note regal was found with revichart past 11/3/16.  The facility policy tit revised 5/12/2016, assessed for smoking assessment and or Rules: #6 A fire retain available to use for determined unsafe #9 A resident who sidetermined unsafe smoking risk assess	ge 26 ngs in the residents progress hange the care plan if needed. er an assessment nor a rding R28's smoking ability ew of R28's computerized  led, Smoking Restrictions, identified: #1 Residents are ing during their admission a quarterly basis. Resident ardant smoking apron will be any resident who had been during the smoking process. smokes, who has been after the completion of the sment will have he cause and ented in their care plan.	F3			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		SURVEY PLETED
		245588	B. WING	_		06/0	06/2017
	PROVIDER OR SUPPLIER	R		2	TREET ADDRESS, CITY, STATE, ZIP CODE 12 WEST SOO STREET, BOX 30 ARKERS PRAIRIE, MN 56361		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	тѕ	Κű	000			
	FIRE SAFETY						
	01 Main Building						
	ALLEGATION OF ODEPARTMENT'S A SIGNATURE AT THE	OC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 WILL BE USED AS F COMPLIANCE.					
	ONSITE REVISIT OF CONDUCTED TO SUBSTANTIAL COREGULATIONS HA	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	Minnesota Departr Fire Marshal Divisi St. Williams Living compliance with th in Medicare/Medica 483.70(a), Life Saf edition of National (NFPA) Standard 1 Chapter 19 Existin	Survey was conducted by the nent of Public Safety, State on. At the time of this survey, Center was found not in e requirements for participation aid at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 101, Life Safety Code (LSC), g Health Care and the 2012 th Care Facilities Code, NFPA			EPOC		
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY					
	Health Care Fire Ir	<u> </u>					(VA) DATE
LABORATOR	V DIDECTORIC OR DROVI	DED/SLIDDLIED DEDDESENTATIVE'S SIG	NIATLIDE		TITI F		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

**Electronically Signed** 

07/03/2017

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.

Facility ID: 00444

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	NG 01 - MAIN BUILDING 01		COMPLETED	
		245588	B. WING	15	06	/06/2017	
14.	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP 212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
K 000	DEFICIENCY ML FOLLOWING INF  1. A description of to correct the def  2. The actual, or  3. The name and responsible for coprevent a reoccur.  The facility was in buildings:  St. Williams Livin with no basement at 6 different time constructed in 19 type II(000) constadded to the sour Type II(111) constadded to the of Type II(1111) constadded to the of Type II(11111) constadded to the of Type II(111111) constadded to the of Type II(11111111) constadded to the of Type II(11111111111111111111111111111111111	al Division treet, Suite 145 01  Distate.mn.us an@state.mn.us  ORRECTION FOR EACH JIST INCLUDE ALL OF THE FORMATION: If what has been, or will be, done	i as				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY
		245588	B. WING			06/0	6/2017
, , , , , , , , , , , , , , , , , , , ,	ROVIDER OR SUPPLIER	R		21	REET ADDRESS, CITY, STATE, ZIP CODE 2 WEST SOO STREET, BOX 30 ARKERS PRAIRIE, MN 56361		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	2007 an addition w was determined to Construction.	f Type V(111) construction. In as added to the southeast that be of Type II(111)	K	000			
	The facility has a fi smoke detection in open to the corrido automatic fire depart	r fire sprinklered throughout. re alarm system that includes the corridors and spaces rs that is monitored for artment notification. The facility 3 beds and had a census of 51 urvey.					
K 133 SS=E	NOT MET. NFPA 101 Multiple	t 42 CFR, Subpart 483.70(a) is Occupancies - Construction	К	133			6/29/17
	Where separated with 18/19.1.3.2 or construction type is building, unless a 2 accordance with 8 construction type is * The construction of the based on the story building in accorda 18/19.1.6.1  * The construction building enclosing based on the appli 18.1.3.5, 19.1.3.5, This STANDARD Based on observated facility failed to material type is the standard or the appli 18.1.3.5, 19.1.3.5, This STANDARD Based on observated in the standard or the standard or the appli 18.1.3.5, 19.1.3.5, This STANDARD Based on observated in the standard or th	ies - Construction Type occupancies are in accordance 18/19.1.3.4, the most stringent is provided throughout the 2-hour separation is provided in 2.1.3, in which case the is determined as follows: type and supporting health care occupancy is in which it is located in the ance with 18/19.1.6 and Tables type of the areas of the the other occupancies shall be cable occupancy chapters. 8.2.1.3 is not met as evidenced by: ation and staff interview the intain the protective opening r fire barriers as listed in the			The one inch diameter hole in 2-hour fire barrier above the cross doors at the 1996 building was filled.	corridor	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION B 01 - MAIN BUILDING 01		SURVEY PLETED
		245588	B, WING		06/0	06/2017
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP ( 212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX T <b>A</b> G	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
K 353	8.3.4.2. This defici spread more quick affect an undeterrand visitors.  Findings include:  1) At 10:01 am on revealed, a one indiffer barrier above to 1996 addition. 2) At 10:11am on cone 3"x8" and one ceiling line of the 2 link.  This deficient cone Facility Administration Director NFPA 101 Sprinkled Testing  Sprinkler System - Automatic sprinkled in spected, tested, with NFPA 25, State Testing, and Maint Protection System maintenance, inspected in a sea available.	IFPA 101 2012 edition, table ent practice could cause fire to ally through a compartment and nined amount of residents, staff  06/06/17 observations on the cross corridor doors at the chapel of the cross corridor doors at the chapel of the	K 13	sheetrock and 3M CP 25W Sealant.  2) The 3"x8" and 2"x4" per above the ceiling line of the barrier at the chapel link we sheetrock and 3M CP 25W Sealant.  The corrections were computed June 29, 2017. The mainternance staff wer for the correction, and the verified by the administrated to prevent a reoccurrence deficiency the maintenance inspect to ensure that a 2-lis properly maintained after penetrations are made from	enetrations e 2-hour fire ere filled with /B+ Fire Barrier  bleted prior to enance director e responsible correction was or. To monitor of the e director will hour fire barrier r any	6/29/17

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G 01 - MAIN BUILDING 01		SURVEY PLETED
		245588	B. WING		06/0	06/2017
	PROVIDER OR SUPPLIER	R	STREET ADDRESS, CITY, STATE, ZIP CODE 212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361			
(X4) ID PREFIX T <b>A</b> G	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 353	any non-required of system.  9.7.5, 9.7.7, 9.7.8, This STANDARD  Based on docume interview, the facilithe sprinkler system.  Life Safety Code (I section 5.2.1.1.2. I maintenance of sprinkler system condition could allow the sprinkler system properly and allow could affect all of the system.	KS information on coverage for or partial automatic sprinkler	K 35	a) A five-year internal pipe in the sprinkler system was com June 29, 2017. The sprinkler inspection included obstruction inspections for all needed loc b) This five-year internal pip was completed by Summit Cocompleted	apleted on a system on ations. e inspection ompanies. source is enance the at monitoring ence of the	
	revealed there was sprinkler system of 5 years.  This deficient conditions and Facility Administration Director NFPA 101 Subdivision of Build Construction 2012 EXISTING Smoke barriers shifter resistance ratio be permitted to ter Smoke dampers and sprinkler systems.	06/07 documentation review is no documentation of a bistruction inspection in the last dition was confirmed by the stor and the Maintenance sion of Building Spaces - Iding Spaces - Smoke Barrier all be constructed to a 1/2-houring per 8.5. Smoke barriers shall minate at an atrium wall. The not required in duct by ducted HVAC systems where	K 37	deficiency by keeping docum the 5-year internal pipe inspe maintenance director's fire dobook.	entation of ction in	6/29/17

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG <b>01 - MAIN BUILDING 01</b>	COMP	PLETED
		245588	B. WING _		06/0	6/2017
	PROVIDER OR SUPPLIER	₹		STREET ADDRESS, CITY, STATE, ZIP CODE 212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 372	smoke compartment barrier.  19.3.7.3, 8.6.7.1(1) Describe any mechain REMARKS. This STANDARD is Based on observatifacility failed to main barriers as required (NFPA 101) section deficient practice of from one smoke confecting the exiting an undetermined at Findings include:  At 10:34 am on 06/the smoke barrier and dining room separative/smoke stopping in the wall penetrate.  This deficient conditional Facility Administrate Director NFPA 101 Evacuation and Research There is a written penetrate and for the an emergency. Employees are perinformed with their	ler system is installed for ints adjacent to the smoke sanical smoke control system is not met as evidenced by: tion and staff interview the intain one of three smoke is by the 2012 Life Safety Code in 19.3.7.3, 8.8.7.1 (1). This could allow smoke to transfer impartment to another in of 11 of the 53 residents and into mount of staff and visitors.  106/07 observations revealed along the great room and into the great room and into interest in a staff and inte	K 3	Fire/smoke stopping was installed the top of the wall and in the wall penetrations of the joist bracing at smoke barrier along the great roor dining room separation. The main director and maintenance staff instance Thermafiber Ultrabatt professional mineral wool at the above-named location. The installation was verified the administrator. The corrections completed prior to June 29, 2017. monitor to prevent a reoccurrence deficiency the maintenance directed administrator will inspect to ensure fire compartments are maintained any new construction is completed.	the m and tenance talled grade fied by were To of the pr and e that after	7/3/17
	an emergency. Employees are per informed with their copy of the plan is operator or with se	iodically instructed and kept				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION  01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245588	B. WING		06/0	6/2017
	PROVIDER OR SUPPLIEI		2	STREET ADDRESS, CITY, STATE, ZIP CODE 212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 711	components per 18.7.1.1 through 18.7.2.3, 19.7.1.1 19.7.2.2, 19.7.2.3 This STANDARD Based on record facility failed to m required in NFPA edition section 19 could cause confusffect all 53 residuamount of staff ar Findings include:  At 8:45 am on 06 revealed the Fire items as specified This deficient cordinates.	all of the fire safety plan 18/19.2.2. 18.7.1.3, 18.7.2.1.2, 18.7.2.2, through 19.7.1.3, 19.7.2.1.2, is not met as evidenced by: review and staff interview the aintain a Fire Safety Plan as 101 Life Safety Code, 2012 0.7.2.2. This deficient practice usion in an emergency and ents and an undetermined nd visitors.	K 711	St. William's Living Center's Fire Evacuation Plan, which includes the Safety Plan, was updated July 3, 2 address all 9 items from the NFPA Life Safety Code, 2012 edition seed 19.7.2.2. The plan was updated wassistance of the Human Resource Director, Director of Nursing, Maindirector, and Administrator. The tridentified above is responsible modufe Safety Code regulations and the Fire Safety Plan as rules channels. William's Living Center staff will educated on the changes to the Fevacuation Plan by July 17, 2017.	ne Fire 2017 to 101 ction with the ses stenance eam snitoring update ge. All ill be ire &	

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(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 02 - NEW BLDG 245588 B. WING. 06/06/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 212 WEST SOO STREET, BOX 30 ST WILLIAMS LIVING CENTER PARKERS PRAIRIE, MN 56361 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLÉTION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRE SAFETY 02 1996 & Chapel Addition THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. Williams Living Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483,70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Health Care Facilities Code, NFPA 99 PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K TAGS) TO:** Health Care Fire Inspections (X6) DATE TITLE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

07/03/2017

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.

Facility ID: 00444

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		IDENTIFICATION AND TO		TIPLE CONSTRUCTION ING <b>02 - NEW BLDG</b>		COMPLETED	
		245588	B. WING		06	/06/2017	
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, 2 212 WEST SOO STREET, BOX S PARKERS PRAIRIE, MN 563	30		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	ODGGG DEFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
K 000	DEFICIENCY MUSE FOLLOWING INFO  1. A description of to correct the defice of the actual, or possible for compressible for com	Division eet, Suite 145 1 state.mn.us n@state.mn.us  PRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done	S				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG <b>02 - NEW BLDG</b>	COMP	PLETED
		245588	B. WING		06/0	6/2017
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO TH	D BE	(X5) COMPLETION DATE
K 133	2007 an addition was determined to Construction.  The building is fully The facility has a famoke detection in open to the corridor automatic fire depahas a capacity of at the time of the second The requirement and NOT MET.	of Type V(111) construction. In was added to the southeast that be of Type II(111)  If ire sprinklered throughout, ire alarm system that includes in the corridors and spaces ors that is monitored for cartment notification. The facility is 3 beds and had a census of 51	К0 К1			6/29/17
	Where separated with 18/19.1.3.2 or construction type i building, unless a accordance with 8 construction type i * The construction of the based on the story building in accordant 18/19.1.6.1 * The construction building enclosing based on the appl 18.1.3.5, 19.1.3.5, This STANDARD Based on observated facility failed to material struction and the story building enclosing based on the appl 18.1.3.5, 19.1.3.5, This STANDARD Based on observated in the structure of	cies - Construction Type occupancies are in accordance 18/19.1.3.4, the most stringent is provided throughout the 2-hour separation is provided in .2.1.3, in which case the is determined as follows: type and supporting health care occupancy is in which it is located in the ance with 18/19.1.6 and Tables type of the areas of the the other occupancies shall be icable occupancy chapters. 8.2.1.3 is not met as evidenced by: ation and staff interview the aintain the protective opening ar fire barriers as listed in the		The one inch diameter hole in 2-hour fire barrier above the cross doors at the 1996 building was fire.	s corridor	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G <b>02 - NEW BLDG</b>	COMF	PLETED
		245588	B. WING		06/0	6/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
K 353	8.3.4.2. This defici spread more quick affect an undeterrand visitors.  Findings include:  1) At 10:01 am on revealed, a one infire barrier above 1996 addition. 2) At 10:11am on ceiling line of the 2 link.  This deficient conceility Administration Director NFPA 101 Sprinkle Testing  Sprinkler System Automatic sprinkle inspected, tested, with NFPA 25, Statesting, and Main Protection System maintenance, inspecial maintenance, inspecial maintenance in a seavailable.	NFPA 101 2012 edition, table ient practice could cause fire to cly through a compartment and mined amount of residents, staff  06/06/17 observations ch diameter hole in the 2 hour the cross corridor doors of the cost corridor doors of the cost corridor above the compartment at the chapel dition was confirmed by the chor and the Maintenance and cordance and standpipe systems are and maintained in accordance and maintained in accordance and maintained in accordance and cordance and testing are accure location and readily asystem last checked system test	K 13	sheetrock and 3M CP 25WB+ Fire Sealant.  2) The 3"x8" and 2"x4" penetratic above the ceiling line of the 2-hou barrier at the chapel link were fille sheetrock and 3M CP 25WB+ Fire Sealant.  The corrections were completed pune 29, 2017. The maintenance and maintenance staff were responsively for the correction, and the correct verified by the administrator. To not o prevent a reoccurrence of the deficiency, the maintenance direct inspect to ensure that a 2-hour fire is properly maintained after any penetrations are made from a correct contract of the deficiency.	ons r fire d with e Barrier  orior to director onsible ion was monitor  tor will e barrier	6/29/17

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			TE SURVEY MPLETED	
		245588	B, WING		06/0	6/2017	
	PROVIDER OR SUPPLIER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 12 WEST SOO STREET, BOX 30 ARKERS PRAIRIE, MN 56361			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 711 SS=F	any non-required of system.  9.7.5, 9.7.7, 9.7.8, This STANDARD Based on docume interview, the facility the sprinkler syste Life Safety Code (section 5.2.1.1.2. maintenance of sprondition could allow could affect all of the sprinkler system could affect all of the sprinkler system of the system of the sprinkler syste	and NFPA 25 is not met as evidenced by: entatjion review and staff ity failed to test and maintain m in accordance with the 2012 NFPA 101) and NFPA 25 The standard for testing and orinkler systems. This deficient ow for the misinterpretation of the spread of fire. This the 53 residents and an ount of staff and visitors.  06/07 documentation review s no documentation of a obstruction inspection in the last dition was confirmed by the ator and the Maintenance	K 353	a) A five-year internal pipe inspect the sprinkler system was completed June 29, 2017. The sprinkler system inspection included obstruction inspections for all needed location b) This five-year internal pipe inswas completed by Summit Compac) The water system supply sour the City of Parkers Prairie.  The administrator and maintenance director were responsible for the correction and will assure that mowill occur to prevent reoccurrence deficiency by keeping documentated the 5-year internal pipe inspection maintenance director's fire documbook.	ed on em  s. pection inies. ce is  ce nitoring of the cion of in entation	7/3/17	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A BUILD	ING (	02 - NEW BLDG	COMP	LETED
		245588	B. WING			06/0	6/2017
NAME OF F	PROVIDER OR SUPPLIER	U			TREET ADDRESS, CITY, STATE, ZIP CODE		
ST WILL	IAMS LIVING CENTE	R			12 WEST SOO STREET, BOX 30 ARKERS PRAIRIE, MN 56361		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 711	components per 18 18.7.1.1 through 18 18.7.2.3, 19.7.1.1 through 18 18.7.2.2, 19.7.2.3 This STANDARD Based on record required in NFPA 1 edition section 19.7 could cause confus affect all 53 resides amount of staff and Findings include:  At 8:45 am on 06/0 revealed the Fire Sitems as specified This deficient conditions.	I of the fire safety plan 3/19.2.2. B.7.1.3, 18.7.2.1.2, 18.7.2.2, through 19.7.1.3, 19.7.2.1.2, is not met as evidenced by: eview and staff interview the intain a Fire Safety Plan as 01 Life Safety Code, 2012 7.2.2. This deficient practice sion in an emergency and ints and an undetermined	K	711	St. William's Living Center's Fire & Evacuation Plan, which includes the Safety Plan, was updated July 3, 2 address all 9 items from the NFPA Life Safety Code, 2012 edition seed 19.7.2.2. The plan was updated wassistance of the Human Resource Director, Director of Nursing, Main director, and Administrator. The tridentified above is responsible moulife Safety Code regulations and uthe Fire Safety Plan as rules channed St. William's Living Center staff will educated on the changes to the Fire Evacuation Plan by July 17, 2017.	ne Fire 1017 to 1011 tion with the es tenance eam intoring update ge. All ll be re &	



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered June 26, 2017

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

Re: State Nursing Home Licensing Orders - Project Number S5588028

Dear Mr. Kelly:

The above facility was surveyed on June 5, 2017 through June 8, 2017 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 <u>only a suggestion</u> 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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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

St Williams Living Center June 26, 2017 Page 2

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 Gail Anderson at (218) 332-5140 or email: gail.anderson@state.mn.us.

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 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 letter.

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

Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

(X6) DATE

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00444	B. WING		06/0	8/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST WILL	IAMS LIVING CENTE	₹	TSOO STRE SPRAIRIE, N	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTENTION*****					
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

07/03/17 **Electronically Signed** 

TITLE

STATE FORM 6899 P04Q11 If continuation sheet 1 of 28

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00444	B. WING		06/0	8/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST WILL	IAMS LIVING CENTE	K	T SOO STRE B PRAIRIE, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically. is necessary for Sta enter the word "cortext. You must then State licensure procompletion date, the corrected prior to e Minnesota Department's staff, the following correction that you and identify the dat Minnesota Department be State Licensing federal software. To assigned to Minnesota Department the State Licensing federal software. To assigned to Minnesota Department be State Licensing federal software. To assigned to Minnesota Department be State Licensing federal software. To assigned to Minnesota Department be state Licensing federal software. To state Licensing federal software. To state and replaces the "It statute/rule out of constitute/rule out of constitute of the Suggested Tindings which are in after the statement evidence by." Followare the Suggested Time period for Constitute of the Suggested T	Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.  d 8th, 2017, surveyors of this visited the above provider and ction orders are issued. Your electronic plan of have reviewed these orders, e when they will be completed.  Then to f Health is documenting a Correction Orders using ag numbers have been sota state statutes/rules for the state statutes in the far left compliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the in violation of the state statute, "This Rule is not met as wing the surveyors findings Method of Correction and rection.  ARD THE HEADING OF THE	2 000			

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 2 of 28 P04Q11

Minnesota Department of Health

	ta Department of Tie		()(0) 1 () () = (-)	E CONCERNATION	()(0) 5:==	OLIDA (E) (
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAIN	OF CONTRECTION	IDENTILIOATION NUMBER.	A. BUILDING:	<del></del>	COIVIPI	1
		00444	B. WING	<del></del>	06/0	8/2017
NAME OF E	PROVIDER OR SUPPLIER	STREET AN	DECC CITY (	STATE, ZIP CODE		
INAIVIE OF F	THOUBEN ON SUFFLIEN					
ST WILL	IAMS LIVING CENTER	₹		ET, BOX 30		
		PARKERS	PRAIRIE, N			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL)		(X5) COMPLETE
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		DATE
17.0			17.0	DEFICIENCY)		
0.000	O	0	0.000			
2 000	Continued From pa	ge 2	2 000			
	THERE IS NO REC	QUIREMENT TO SUBMIT A				
	PLAN OF CORREC	CTION FOR VIOLATIONS OF				
	MINNESOTA STATE STATUTES/RULES.					
2 510	MN Rule 4658.0300	Subp. 2 Use of Restraints	2 510			7/17/17
						.,,
	Subp. 2. Freedom	from restraints. Residents				
	must be free from any physical or chemical					
	restraints imposed for purposes of discipline or					
		ot required to treat the				
	resident's medical s					
		,				
	This MN Requireme	ent is not met as evidenced				
	by:					
	Based on observati	on, interview and document		For resident (R51) a Self Release	Alarm	
	review the facility fa	iled to ensure the use of a		Belt (SRAB) elimination/reduction	is to be	
		belt (SRAB), (which alerted		completed. If resident (R51) is no	t able to	
	staff of attempted w	heelchair exits) was not used		unable to remove the SRAB by he	rself by	
	as a physical restra	int for 1 of 1 residents (R51)		July 3, 2017, it will be assessed as	а	
	reviewed for restrai	nts.		restraint.		
	Findings include:			All residents with an SRAB will have	/e	
	Davidson of DE41:	aval Minimum Data Cat		reduction/elimination completed if		
		nual Minimum Data Set		applicable at least quarterly. Nurs		
	,	7, identified R51 had		assure weekly that resident can re		
	· ·	cluded dementia and arthritis.		the SRAB per self. If resident is no		
		entified R51 had severe		to release belt per self, it will be as		
	•	nt and required extensive		as a restraint per facility policy. The	ie Self	
		activities of daily living (ADL's)		Release Alarm Belt Policy, Alarm		
		he MDS indicated R51 had no		Reduction Policy, Restraint Assess		
	physical restraints.			and Self Release Alarm Belt Asses		
				were reviewed and updated prior to	o July 3,	
		sessment (CAA) dated		2017.		
		R51 had dementia, arthritis,				
		mobility, and staff were to		Nursing staff will be educated at nu		
		s and provide extensive		meeting July 12, 2017 and all othe		
	assistance with ADI	's The CAA failed to identify		will be educated by July 17, 2017	Tho	

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00444	B. WING	·····	06/0	8/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST WILL	IAMS LIVING CENTE	₹	PRAIRIE, N	ET, BOX 30 IN 56361		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 510	Continued From pa	ge 3	2 510			
	R51 had impaired of making skills. The of required extensive staff were to anticip R51's safety and con R51 would release she had to use the transfer into bed. The may sit in a regular and activities without to release the SRAI the dining room quil Review of R51's Sedated 4/13/17, iden had arthritis. The as R51 was educated	ant dated 6/8/2017, identified cognition and poor decision care plan further identified R51 assistance with ADL's, and ate her needs to maintain omfort. The care plan indicated her SRAB to alert staff when bathroom or wanted to he care plan indicated R51 dining room chair at meals at an alarm, and it was ok not B at meals due to R51 leaving ckly and was a fall risk.  If Release Belt Assessment tified R51 was disoriented and assessment further identified on the reason for the SRAB, SRAB worked and was able		medical director will be updated or policy changes on July 11, 2017. Director of Nursing will complete raudits of all residents that have SI ensure policy is being followed. Fix will be discussed at QA committee meetings quarterly to ensure com	The andom RAB to Results	
	seated in the dining table for the supper full of residents as a provided assistance tables. R51 wore a a white plastic hook closed around R51' wheelchair. R51 sa residents and ate h. On 6/07/17, at 1:50 wheelchair in front owere a blue Velcro plastic hook and locaround R51's waist	23 to 5:43 p.m. R51 was room in her wheelchair at the meal. The dining room was staff served meals and to other residents at their blue Velcro lap belt which had and loop closure which s waist and sides of her at the table with other er meal independently.  p.m. R51 was seated in her of the nurse's station. R51 lap belt which had a white op closure which was closed and sides of her wheelchair. On her lap and both hands				

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00444	B. WING		06/0	8/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•	
ST WILL	IAMS LIVING CENTE	<b>∺</b>	SOO STRE	-		
		PARKERS	PRAIRIE, N	IN 56361		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 510	shook in a tremor at the belt and the wh Nursing assistant (Inurses station. Durwas confused and with her ADL's. She self-release alarm and stated she thou herself.  On 6/7/17, at 1:52 pwith surveyor in from asked R51 several SRAB off while she it by opening her arnot attempt to remover the words "tapiece of white paper face for her to read release the SRAB areleased R51's SRAB and continuer releasing the SRAB and talked under her on 6/08/17, at 9:37 confused and requirables. NA-H stated R51 had used the SR	and rubbed against the top of the closure of the SRAB.  NA)-C was also present at the ting interview, NA-C stated R51 required extensive assistance a stated R51 had worn the celt (SRAB) for a year or 2, ught R51 could release the belt of the nurses station. NA-C times out loud to take her demonstrated how to release ms in a quick motion. R51 did ove the SRAB. NA-C then ke off your seat belt" on a car and put up close to R51's.  R51 did not attempt to after written request. NA-C AB and demonstrated how to or R51. NA-C reapplied R51's and to act out the action of B. R51 made no attempt to and just smiled, belly laughed	2 510			
	release the SRAB of use the bathroom release the SRAB of only removed it for to bed or when they She stated R51 use	on her own when she had to ght away, and stated it had ks since she observed R51 on her own. She stated staff meals, at night when she went or put her in a regular chair. and R51 mostly liked to				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00444	B. WING		06/0	8/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ST WILL	IAMS LIVING CENTE	R	PRAIRIE, N	ET, BOX 30 IN 56361		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 510	Continued From page 5 roam around the facility in her wheelchair.		2 510			
	On 6/08/17, at 9:43 cognitively impaired with ADL's. She stated the SR51 could release stated she had nev SRAB on her own. when they take her dining room.  On 6/8/17, at 9:56 a confused and requiher ADL's. She stated SRAB for about a y self-transfers. She release the belt by the bathroom immed thought the last time the SRAB on her or	a.m. NA-I stated R51 was and required staff assistance ated she wasn't sure how long RAB. She stated she thought the SRAB but she did not, and er seen R51 release the She stated staff released it to the bathroom and in the a.m. NA-J stated R51 was red extensive assistance with ed she thought R51 had the ear to prevent unsafe stated R51 probably could not herself, unless she had to use ediately. She stated she e she observed R51 release wn was about a couple months a SRAB was released at				
	chair. On 6/8/17, at 10:12	a.m. licensed practical nurse was confused and required				
	assistance with all of R51 had the SRAB stated it was to preher own. She stated was last able to release to stated they remake in bed and who toileting. She said repeated to remove they could remove	cares. She stated she thought for more than a year, and went R51 from getting up on d she wasn't sure when R51 ease the SRAB on her own. noved the SRAB when she en staff assisted R51 with esidents at the facility had to the SRAB and demonstrate it on their own before the She stated if R51 couldn't get				

6899

Minnesota Department of Health

STATEMENT OF DEFICIEN AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		SURVEY PLETED
		00444	B. WING		06//	08/2017
NAME OF PROVIDER OR				STATE ZID CODE	1 00/0	JO/2U11
NAME OF PROVIDER OR S	SUPPLIER		T SOO STRE	STATE, ZIP CODE		
ST WILLIAMS LIVING	CENTE	K	S PRAIRIE, N			
PREFIX (EACH D	EFICIENC'	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
stated R51 assistance the SRAB sinjury. She unable to r stated she since R51 own. She s as they felt a physical R51's SRA them to tra chair and v  On 6/8/17, interview w R51 could and stated SRAB in th  NM-B conf SRAB was R51 was a She stated her own it v confirmed they did no SRAB on h  On 6/08/17 stated the s physical re R51 could R51 may n SRAB on h SRAB on h	was conwith AD since 7/1 stated selease the was not was ablestated the the SR/restraint B in the nsfer he when R5 at 11:10 not release he felt e past. From the SR/restraint for	age 6  18 a.m. nurse manager (NM)-A infused and required extensive L's. She stated R51 has had 10/14 after she had a fall with the was not aware R51 was he SRAB on her own, and sure how long it had been to release the SRAB on her ey had never tried a reduction AB was a safety device and not. She stated the staff released dining room if she would allow or into a regular dining room 1 was toileted.  19 a.m. NM-B joined the A and stated she was unaware ase her SRAB on command R51 was able to remove her sted 4/13/17 and it identified lease the SRAB on her own. Sould not release the SRAB on a physical restraint. She aphysical restraint. She aphysical restraint. She in between assessments.  20 p.m. director of nurses (DON) id not see the belt as a or R51 because she thought it if she wanted to. She stated twe been able to release the decause of her dementia. was unable to remove her it was a physical restraint.				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		OATE SURVEY OMPLETED	
		00444	B. WING		06/0	8/2017	
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE			
ST WILL	IAMS LIVING CENTE	K	PRAIRIE, N	ET, BOX 30 IN 56361			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 510	Continued From pa	ge 7	2 510				
	would have a comp problems/needs ide restraints and would to achieve and/or m physical, mental an SUGGESTED MET The director of nurs implement policies identification and as restraints and educ The quality assessr	id/2016, identified each resident brehensive assessment with centified which included physical difference the care necessary naintain their highest practical difference psychological well-being.  THOD FOR CORRECTION: Sing (DON) or designee could and procedures related to essessment of physical tate staff on these policies. The ment and assurance erform random audits to					
	days.	R CORRECTION: Twenty (21)					
2 565	MN Rule 4658.0408 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			7/17/17	
		omprehensive plan of care I personnel involved in the i.					
	by: Based on observati review, the facility fordered use of ther stockings (designed swelling) as identifie	ent is not met as evidenced ions, interviews and document ailed to follow physician apeutic compression d to help relieve aches and ed on the resident's written f 3 residents (R66) reviewed.		Resident R66 now has nurse follow Treatment Administration Record ( assure resident has his compressi stockings applied on and off per ca If resident, the nurse will chart his in resident s record after education risks/benefits of compressions sto	(TAR) to on are plan. refusal ng on		

Minnesota Department of Health

Minnesota Department of Health

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00444	B. WING	<del></del>	06/0	8/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		212 WEST		ET, BOX 30		
ST WILL	IAMS LIVING CENTE	K	PRAIRIE, N	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ne 8	2 565	,		
_ 000	'	.900				
	Findings include:			All regidents who have compressi	<b>.</b>	
	R66's care plan dat	ted 6/6/17, identified R66 had		All residents who have compression stockings ordered have had nurse		
		veakness and potential for		follow-up added to their TAR to as		
		are plan further identified R66		that residents have their compress		
	was independent w	ith dressing and was to utilize		stockings on/off per care plan. Nu	ırse will	
		h compression stockings every		chart refusals in resident s record	d after	
		indicated R66's compression		educating on risks/benefits of		
		e on in the morning and off at		compressions stockings.		
	H.S. (hour of sleep)	).		Nursing staff will be educated at n	ureae	
	Review of the nursi	ng assistant (NA) daily care		meeting July 12, 2017 and all other		
		identified R66 was to use		will be educated by July 17, 2017.		
		h compression stockings, on		medical director will be updated or		
	every morning and	off at bedtime.		policy changes on July 11, 2017.		
				Director of Nursing will complete r	andom	
		p.m. R66 was seated in his		audits of all residents that have		
		nair, both feet rested on the up to his calves were swollen		compression stockings to ensure being followed. Results will be dis		
		indentations around the		at QA committee meetings quarter		
		oth calves from where the		ensure compliance.	ly to	
		top of his regular white socks		F 33		
		t wearing compression				
		leg. He stated he required				
		the compression stockings				
	and staff were supp	s in the morning and take them				
		ne went to bed. R66 stated the				
		s were ordered to reduce				
	•	his legs. He stated he felt				
	some staff were ab	sent minded and forgot to put				
		nem off. He stated in the past				
		compression socks on the				
		to get staff's attention so they				
		o put them on. He stated the kept the swelling down in his				
	legs.	ropt the swelling down in tils				
	.595.					
		p.m. R66 was in his room chair with regular black socks				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SU COMPLE	
		00444	B. WING		06/0	8/2017
	PROVIDER OR SUPPLIER	212 WFS	DRESS, CITY, S	TATE, ZIP CODE ET, BOX 30		
31 WILL	IAMS LIVING CENTER	PARKERS	S PRAIRIE, M	N 56361		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	on both feet and was socks to either leg. around his mid calve top of his socks we wear these socks be and his legs swelled compression socks supposed to put the day and indicated sor remove his comphad not worn his considerable because staff had repolying the compression socks morning his legs were he felt there is a fer and a lot he could remore and he did because it aggravation of 6/06/17, at 3:14 required assistance socks. She stated to them on every day, refused. She stated to usually let the nurse convince him to put thought R66 always.  On 6/06/17, at 3:22 needed help with his stated either the nurse convince him to put thought R66 always. On 6/06/17, at 3:22 needed help with his stated either the nurse convince him to put thought R66 always. On 6/06/17, at 3:22 needed help with his stated either the nurse convince him to put thought R66 always. On 6/06/17, at 3:22 needed help with his stated either the nurse convince him to put thought R66 always. On 6/06/17, at 3:22 needed help with his stated either the nurse convince him to put thought R66 always. On 6/06/17, at 3:22 needed help with his stated either the nurse convince him put on. He stated R66's	as not wearing compression R66 had deep indentations where the elastic from the re. R66 stated he should not ecause they were too tight, dup quickly without the on. He stated staff were ecompression socks on every taff did not consistently apply pression socks. R66 stated he empression socks for 2 days not offered to assist with ession stockings. He stated is compression socks they take them off and then in the ere uncomfortable. He stated we staff he could can rely on not rely on. He stated he did n because he felt that made if not want to use his call light	2 565			

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Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00444	B. WING		06/0	8/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
ST WILL	IAMS LIVING CENTE	R	SOO STRE	-		
			PRAIRIE, N			T
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 10	2 565			
	compression socks	helped a lot with his swelling.				
	stated R66 required applying and remove RN-A indicated R66 the compression so a pattern of refusing physician of any refusive current order for the stated she expected every morning and stated R66 had a local day to day.	o.m. registered nurse (RN)-A d staff's assistance with ving his compression socks. Socasionally refused to wear ocks, however; he did not have g and they had not notified his fusals. She confirmed R66's e compression socks and d the NA's to put them on take them off every night. She of of edema, which varied from				
	entered R66's room recliner with his fee and wore regular bl had both socks pus and was not wearin either leg. RN-A co compression socks should have put the R66, "Why aren't yo socks?" R66 replied	o.m. RN-A and surveyor a. R66 was seated in his at elevated on the foot rests ack socks on both feet. R66 shed down around his ankles ag his compression socks to affirmed R66 did not have his a on either leg, and stated staff am on this morning. RN asked but wearing your compression at the staff forgot and I did not because it aggravated people.				
	required assistance compression socks and cooperative who compression socks responsible to apply document when the off. She stated R66 morning and should applying his compression stated R66's stated R	a.m. NA-G stated R66 with applying his . She stated R66 was thankful ien staff helped put his on. She stated the NA's were y R66 compression socks and ey put them on and took them got up on his own in the d have assistance with ession socks before breakfast. welling in his legs was better his compression socks, and				

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Minnesota Department of Health

AND DIAN OF CODDECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00444	B. WING	<del></del>	06/0	8/2017
	PROVIDER OR SUPPLIER	212 WEST	DRESS, CITY, S F SOO STRE 5 PRAIRIE, M	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	on 6/08/17, at 10:2 confirmed R66 had compression socks from arthritis. She sapply R66's compremorning and take the theorem and take th	helped to reduce R66's  8 a.m. nurse manager (NM-A) a current physician's order for for chronic swelling in his legs stated she expected staff to ession stockings every nem off at bedtime as directed ne stated R66 required help and removal of his	2 565			
	Care Plans dated 6 would ensure care	y policy, Assessments and /2016, identified the facility plans were appropriate and ently to meet each resident's				
	The director of nurs implement policies ensuring staff imple educate staff on the assessment and as	HOD FOR CORRECTION: sing (DON) or designee could and procedures related to ment resident care plans and ese policies. The quality surance committee could dits to ensure compliance.				

6899

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING	TE SURVEY MPLETED	
		00444	B. WING		/08/2017
	PROVIDER OR SUPPLIER	212 WEST		STATE, ZIP CODE SET, BOX 30 IN 56361	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From pa	ge 12	2 565		
	TIME PERIOD FOR days.	R CORRECTION: Twenty (21)			
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830		7/17/17
	receive nursing carcustodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ang home resident must be out possible unless there is a the attending physician that the in in bed or the resident bed.			
	by: F323 and F282 Based on observatireview the facility faimplementation of ainjury for 1 of 1 resirequired a smoking the facility failed towere followed for 1 compression stockir Findings include: R28's significant ch (MDS) dated 11/1/1	ent is not met as evidenced on, interview and document illed to ensure consistent a smoking apron to prevent dents (R28) reviewed who apron for safety. In addition, ensure care plan interventions of 1 resident for use of ngs.  ange Minimum Data Set 6, identified R28 had impairment and diagnoses		Resident R28 had a smoking assessmer completed on June 6, 2017. The smoking apron was removed from resident's Care plan/Kardex as determined for the assessment. All residents were audited determine who smoked and no other residents smoked at that point in time.  The smoking restrictions policy was updated June 20, 2017. The Assessments and Care Plans policy was updated on June 21, 2017. An auditing form was developed to assure all assessments and care plans are completed per the facility policy and	g

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE S COMPL	
	00444	B. WING		06/08	3/2017
NAME OF PROVIDER OR SUPPLIER	<u> </u>	DRESS, CITY, S	STATE, ZIP CODE	1 00,00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
ST WILLIAMS LIVING CENTER		SOO STRE	-		
PREFIX (EACH DEFICIENCY MI	EMENT OF DEFICIENCIES JUST BE PRECEDED BY FULL DESIGNATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
anxiety. The MDS iderextensive assistance of (ADL's,) including amb. The MDS did not identobacco products.  R28's quarterly MDS R28 had severe cognical diagnoses which inclused to required ADL's. The MDS did result to the diagnoses which inclused to the diagnoses which inclused to required ADL's. The MDS did result to the diagnoses which inclused to the diagnoses identified R28 had cognicated and referent from facility staff with diagnette. The smoking R28 required one on a smoking. The assessing required the use of a second fire retardant materials and during smoking.  R28's care plan revised was a current active second included; smoking, staff to store materials, light tobacconsident's safety during identified staff could second with R28 in sight while on 6/05/2017, at 4:51 assistant (TMA)-A entities.	ntia, epilepsy, chronic y disease (COPD) and entified R28 required with areas of daily living abulation and locomotion. In tify whether R28 used a dated 4/19/17, identified nitive impairment and had uded dementia, epilepsy, the MDS identified R28 extensive assistance with not identify whether R28 ts.  I extensive assistance with not identify whether R28 ts.  Issment dated 11/3/16, and lighting the negassessment identified one staff supervision when sment further identified R28 smoking apron (apron made rial worn to protect against ag.  Led 1/26/17, identified R28 smoker. The care plan extension for R28's smoking aron e, distribute R28's smoking co products, staff to monitor neg smoking. R28's care plan etand inside the facility door,	2 830	resident needs.  Nursing staff will be educated at meeting July 12, 2017 and all other will be educated by July 17, 2017. medical director will be updated or policy changes on July 11, 2017. Director of Nursing will complete maudits of the to ensure that assess and care plans are being complete the facility policy and resident need Results will be discussed at QA comeetings quarterly to ensure compared to the provided state of the compared to the provided state of the compared to the provided state of the compared to the	er staff The The In final The andom sments ed per ds. ommittee	

Minnesota Department of Health

Minnesota Department of Health

		SURVEY			
	00444	B. WING		06/0	08/2017
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ST WILLIAMS LIVING CENTE	K	T SOO STREE S PRAIRIE, MI	-		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
propelled her whee and out to the smo TMA-A passed by taprons hanging by foyer, however; did TMA-A handed R20 lighter for R28 to ligit cement blocks surresceptaces. R28 in cigarette, smoked, extinguished the cireceptacle. Although dated 11/3/16, iden smoking apron R20 apron nor was one  On 6/06/2017, at 9 wheelchair outside director (AD)-A who against the outside smoking patio. R28 on. R28 was seates smoking receptace independently smoextinguished the cirector of 6/05/2017, at 9 required staff assist needed facility staff smoked. TMA-A in assessment and canot aware R28 needed facility staff smoked. TMA-A in assessment and canot aware R28 needed facility staff smoked. TMA-A in assessment and canot aware R28 needed facility staff smoked. TMA-A in assessment and canot aware R28 needed facility staff smoked. TMA-A in assessment and canot aware R28 needed facility staff smoked. TMA-A in assessment and canot aware R28 needed facility staff smoked. TMA-A in assessment and canot aware R28 needed facility staff smoked. TMA-A in assessment and canot aware R28 needed facility staff smoked. TMA-A in assessment and canot aware R28 needed facility staff smoked. TMA-A in assessment and canot aware R28 needed facility staff smoked. TMA-A in assessment and canot aware R28 needed facility staff smoked. TMA-A in assessment and canot aware R28 needed facility staff smoked. TMA-A in assessment and canot aware R28 needed facility staff smoked. TMA-A in assessment and canot aware R28 needed facility staff smoked. TMA-A in assessment and canot aware R28 needed facility staff smoked.	alked with R28 as she el chair through a small foyer king patio. Both R28 and two white colored smoking hooks on the wall of the small not obtain a smoking apron. 8 the cigarette and ignited the ght her cigarette. TMA-A sat on rounding the flower garden independently handled the placed the ash and garette in the provided metal gh R28's smoking assessment itified the need for use of a did not wear a smoking offered to her.  2:40 a.m. R28 was seated in a the facility with activities o was seated in a chair wall of the facility on the did not have a smoking apron d in the wheelchair next to the with her back to AD-A. R28 ked, disposed of ashes and				

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUI COMPLET  A. BUILDING: (X3) DATE SUI COMPLET					
		00444	B. WING		06/0	08/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST WILL	IAMS LIVING CENTE	<b>⊀</b>	T SOO STRE S PRAIRIE, M	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 830	with her while she shad poor short term smoke often. AD-A cigarette right after poor memory.  On 6/06/2017, at 1 (NA)-A indicated and to smoke. NA-A state smoking materials is smoking apron was hung on the wall in would apply the smand sit with R28 under the smoking apron burned.  On 6/06/2017, at 2 cigarette and lighter medication room. Nother smoking materioutside, place a smoking. NA-B indicated in case R28 dinased R28 as she independent in the case R28 dinased R28 into the cigarette case dinased R28 into the cigarette ca	smoked. AD-A indicated R28 in memory and requested to indicated R28 may request a smoking one because of her :52 p.m. nursing assistant by facility staff could assist R28 ted staff would obtain the from the nurses station, a stretrieved from a hook which the foyer. NA-A indicated staff oking apron, light the cigarette till she finished. NA-A stated was used so R28 would not :02 p.m. NA-B indicated R28's rewere locked in the IA-B indicated staff would get als from a nurse, take R28 oking apron on R28, light the with R28 until she was finished cated the smoking apron was ropped ashes on herself. The had not seen R28 drop a but had witnessed her drop :35 p.m. R28 was seated in a smoking patio. R28 wore a smoking patio.	2 830			
		find AA-A and request he/she				

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STATEMENT OF DEFICIENCIES (X1)

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. DUILDING:	<del></del>		
		00444	B. WING		06/0	8/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST WILL	IAMS LIVING CENTE	R	T SOO STRE S PRAIRIE, N	ET, BOX 30 NN 56361		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 16	2 830			
	sit with R28 while s smoking materials medication room, a placed on R28 so the and staff would the finished smoking.  On 6/06/2017, at 3 was reviewed with NM-A confirmed the assessment was coverified the assessing use of a smoking a current care plan dismoking apron. No practice was for ear as directed by the a indicated when an a such as a smoking	he smoked. AA-A indicated were retrieved from the smoking apron would be nat she would not burn herself en sit and visit until R28 is  :16 p.m. R28's medical record nurse manager (NM)-A.  e most recent smoking ompleted on 11/3/16. NM-A ment noted R28 required the pron. NM-A confirmed R27's d not direct the use of a M-A indicated the usual facility ch resident care be provided assessment findings. NM-A assessment identified a need apron the smoking apron to be utilized each time the				
	nursing (DON) indice perform an initial stream admission and their status. The DON verified R28's was completed 11/3 been completed in indicated being una cognition or physical assumed if the care discontinue the use assessment should DON further indicated.	c:42 p.m. the director of cted the facility protocol was to moking assessments upon a quarterly or with a change in crified all smoking completed in the computer of R28's medical record, the last smoking assessment 3/16, and one should have February 2017. The DON aware of a change in R28's all condition, however; a plan was changed to e of the smoking apron, and have been completed. The steed R28 had previously used a tugh felt R28 no longer				

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STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:	<del></del>	COMP	LETED
		00444	B. WING		06/0	8/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST WILL	IAMS LIVING CENTE	K	T SOO STRE S PRAIRIE, M	EET, BOX 30 NN 56361		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 17	2 830			
	On 6/06/2017, 4:07 responsible for disc smoking apron fron verified the most cu was dated 11/3/16, apron was to be uti with smoking for R2 practice was to condocument the findir notes and then to c NM-B verified neith progress note rega was found with revichart past 11/3/16.	7 p.m. NM-B indicated being continuing the use of the n R28's care plan. NM-B urrent smoking assessment and it indicated a smoking lized in order to ensure safety 28. NM-B indicated the usual aplete an assessment, ags in the residents progress hange the care plan if needed. er an assessment nor a rding R28's smoking ability ew of R28's computerized				
	5/16/17, revealed a knee high gradient placed on in the modern placed on included arthritis, placed ma. The MDS from the cognitively intact are activities of daily lived placed of R66's Caracter and placed pl	rrent physician orders dated in order started 3/12/17, for pressure stockings to be brining and off in the evening.  Inimum Data Set (MDS) dated 166 had diagnoses which 166 had diagnoses which 166 ain, weakness and localized 166 was 160 dependent with all 161 ing (ADL's) except toileting.  In are Area Assessment (CAA) 161 tified R66 had weakness, 161 tion, poor coordination and 162 ain and 163 cognitive impairment 163 itive status. The CAA further 164 itive status. The CAA further 165 itied R66 had edema or 165 socks.				
	R66's care plan dat	ted 6/6/17, identified R66 had				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIEN AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00444	B. WING		06/0	8/2017
NAME OF PROVIDER OR	SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST WILLIAMS LIVING	CENTE	K	「SOO STRE S PRAIRIE, N	ET, BOX 30 NN 56361		
PREFIX (EACH D	EFICIENC	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
arthritis pai was indeped knee high/st day. The castockings was indeped knee high/st day. The castockings was indeped knee high/st every more. Review of and treatm to 6/8/2017 compression. On 6/05/17 room in his floor. R66's and had significant compression off at night compression off at night compression swelling and staff was compression of a staff them on a staff them on a staff them on a staff the would get to stocking staff the staff t	in bility, vin. The condent we thigh high are plan were to be of sleep the nurside 6/8/17, thigh high hing and R66's ment admirated for stock on stock on stock on either to apply the sock of series and take the condens of the conde	veakness and potential for are plan further identified R66 ith dressing and was to utilize h compression stockings every indicated R66's compression be on in the morning and off at	2 830			

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00444	B. WING		06/0	8/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST WILL	IAMS LIVING CENTE	K .	SOO STRE			
			PRAIRIE, N	PROVIDER'S PLAN OF CORRECTION	- N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 19	2 830			
	On 6/06/17, at 2:35 seated in his wheel on both feet and was socks to either legaround his mid calve top of his socks we wear these socks be and his legs swelled compression socks supposed to put the day and indicated sor remove his comphad not worn his comphad not worn his compression socks supposed to put the day and indicated sor remove his comphad not worn his cobecause staff had rapplying the comprewhen staff do put his sometimes forgot to morning his legs when felt there is a feand a lot he could ranot want to complate enemies and he did because it aggrava.  On 6/06/17, at 3:03 required extensive remove his compremove his comprementation has been detailed by the history has been detailed	is p.m. R66 was in his room chair with regular black socks as not wearing compression R66 had deep indentations we where the elastic from the re. R66 stated he should not because they were too tight, dup quickly without the son. He stated staff were excompression socks on every staff did not consistently apply pression socks. R66 stated he empression socks for 2 days not offered to assist with ession stockings. He stated is compression socks they take them off and then in the ere uncomfortable. He stated w staff he could can rely on not rely on. He stated he did in because he felt that made do not want to use his call light ted the staff.				

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On 6/06/17, at 3:22 p.m. NA-K stated he felt R66

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STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00444	B. WING		06/0	8/2017
-	ROVIDER OR SUPPLIER	212 WEST	SOO STRE	-		
		PARKERS	PRAIRIE, N	IN 56361		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
	stated either the nu compression socks wear them every darefuse to wear the complete to wear the complete to wear the compression socks a pattern of refusing physician of any refurent order for the stated she expected every morning and stated R66 had a loady to day.  On 6/6/17, at 3:35 pentered R66's room recliner with his fee and wore regular blead both socks pus and was not wearing either leg. RN-A concompression socks should have put the R66, "Why aren't you socks?" R66 replied want to complain be on 6/07/17, at 7:16 required assistance	s compression socks. He rse or the NA's applied R66's and R66 was supposed to be and R66 was supposed to be and R66 was supposed to be and R66 had fold him the and R66 had told him the helped a lot with his swelling.  The answer is assistance with ring his compression socks. The cocasionally refused to wear ocks, however; he did not have grand they had not notified his usals. She confirmed R66's are compression socks and do the NA's to put them on take them off every night. She at of edema, which varied from the compression socks and do the NA's to put them on take them off every night. She at of edema, which varied from the foot rests ack socks on both feet. R66 and down around his ankles go his compression socks to firmed R66 did not have his on either leg, and stated staff and on this morning. RN asked to wearing your compression the staff forgot and I did not because it aggravated people.	2 830			

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STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00444	B. WING		06/0	8/2017
-	PROVIDER OR SUPPLIER	212 WEST	DRESS, CITY, S SOO STRE PRAIRIE, M	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	.D BE	(X5) COMPLETE DATE
2 830	compression socks responsible to apply document when the off. She stated R66 morning and should applying his compression socks as long as he wore stated she felt they swelling.  On 6/08/17, at 10:2 confirmed R66 had compression socks from arthritis. She sapply R66's compremorning and take the total she question documentation of stated she question documentation, as wear them more the revealed.  On 6/08/2017, at 1 interview NM-A stated for applying R66's compremorning and take the compression socks documentation of stated she question documentation, as wear them more that revealed.  On 6/08/2017, at 1 interview NM-A stated the documentation multiple days she with the documentation mult	on. She stated the NA's were y R66 compression socks and by put them on and took them got up on his own in the dhave assistance with ession socks before breakfast. Welling in his legs was better his compression socks, and helped to reduce R66's  8 a.m. nurse manager (NM-A) a current physician's order for for chronic swelling in his legs stated she expected staff to ession stockings every nem off at bedtime as directed he stated R66 required help and removal of his. She confirmed the ded's compression socks and hed the accuracy of the she thought he refused to an the documentation  104 p.m. during follow-up the ded he NA's were responsible compression socks and lis in the computer. She stated in identified several refusals for rould address it with the ted she had not personally an with any refusals, and of R66 when he refused to ion socks. She stated the were a necessary treatment	2 830			

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Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				B) DATE SURVEY COMPLETED	
00444		B. WING		06/08/2017			
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
ST WILL	IAMS LIVING CENTER	<b>∺</b>	SOO STRE PRAIRIE, M	-			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 22	2 830				
	Review of R66's on socks from 3/12/17	and off schedule for JOBST to 6/8/17 revealed:					
		66 had his compression socks ing and removed every night of					
	4/1/17-4/30/17, R66 had his compression socks applied every morning and removed every night with the exception of 1 day.						
	5/1/17-5/31/17, R66 had his compression socks applied every morning and removed every night with the exception of 1 day and 1 refusal.						
	6/1/17-6/8/17, R66 had his compression socks applied every morning and removed every night with the exception of 2 days. The documentation also identified staff indicated they applied R66's compression socks on 6/5/17 and 6/6/17 despite observation of R66 without them on.						
	On 6/08/17, at 1:20 p.m. director of nurses (DON) stated the compression socks were a necessary treatment for R66 to improve circulation and reduce edema in his legs. The DON stated she expected staff to apply and remove R66's compression socks as directed by the care plan.						
	On 6/08/17, at 1:45 p.m. during telephone interview, nurse practitioner (NP) stated the compression stockings were specifically ordered for R66's bilateral (left and right) edema. She stated she would expect the facility to follow the physicians order for the compression stockings						

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA				TE SURVEY MPLETED	
00444		B. WING		06/08/2017			
212 WEST			ORESS, CITY, S	ETATE, ZIP CODE ET, BOX 30			
31 WILL	IAMS LIVING CENTE	PARKERS	PRAIRIE, N	IN 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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	JLD BE COMPLETE		
2 830	Continued From pa	ge 23	2 830				
	On 6/08/17, at 2:20 p.m. during telephone interview, R66's physician stated R66 had edema and knee pain. He stated the compression socks were ordered for swelling. He stated he was not aware R66 was opposed to wearing the compression socks. He stated he would expect the facility to follow the order for R66's use of compression socks.  Review of the facility policy, Assessments and Care Plans dated 6/2016, identified the facility would ensure care plans were appropriate and carried out consistently to meet each resident's specific needs.  The facility policy titled, Smoking Restrictions, revised 5/12/2016, identified: #1 Residents are assessed for smoking during their admission assessment and on a quarterly basis. Resident Rules: #6 A fire retardant smoking apron will be available to use for any resident who had been determined unsafe during the smoking process. #9 A resident who smokes, who has been determined unsafe after the completion of the smoking risk assessment will have he cause and approaches documented in their care plan.  SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could implement policies and procedures related to ensuring staff implement resident physician orders and care plans and educate staff on these policies. The quality assessment and assurance committee could perform random audits to ensure compliance.  TIME PERIOD FOR CORRECTION: Twenty (21) days.						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
00444		B. WING		06/08/2017				
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE				
ST WILL	IAMS LIVING CENTE	<b>-</b>	T SOO STRE S PRAIRIE, N	ET, BOX 30 IN 56361				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE		
2 850	Continued From pa	ge 24	2 850					
2 850	MN Rule 4658.0520 Proper Nursing Car	Subp. 2 D Adequate and e; Shaving	2 850			7/17/17		
	proper care. The cadequate and proper D. Assistance	r determining adequate and criteria for determining er care include: with or supervision of shaving necessary to keep them clean						
	by: Based on observative review the facility facility facility facility facility facility facility facility.	ent is not met as evidenced on, interview and document illed to provide grooming the removal of facial hair for 1 observed to have significant		Resident R51's daughter was calle electric shaver was brought to fac family for resident's use. The resi was shaved by staff on June 10, 2	ility by dent 1017.			
	(MDS) dated 4/19/1 diagnoses which in pain. The MDS furt cognitive impairmen	nual Minimum Data Set 7, identified R51 had cluded dementia, arthritis and ner identified R51 had severe nt and required extensive activities of daily living (ADLs)		All residents were asked if they was be shaved. Any residents that did want to be shaved had this inform added to their care plan/Kardex. who wanted to be shaved were at see if they had their own shaver, if family was contacted to bring in a for them.	not ation Those dited to			
	except for eating.  R51's Care Area As 4/21/17, identified F and restricted mobi staff were to anticip extensive assistance.  Review of R51's calidentified R51 requi	sessment (CAA) dated R51 had dementia, arthritis lity. The CAA further identified ate R51's needs and provide		The Shaving Policy was reviewed updated on June 21, 2017. Socia Services will ask upon admission resident wants to be shaved. If re does not want to be shaved, the information will be added to their oplan. If the resident does want to shaved, an electric razor will be br by resident or family.  Nursing staff will be educated at meeting July 12, 2017 and all other	I if sident care be cought in			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
00444		B. WING		06/08/2017		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ST WILL	IAMS LIVING CENTE	<b>∺</b>	SOO STRE PRAIRIE, M	ET, BOX 30 NN 56361		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 850	Continued From page 25		2 850			
	On 6/05/17, at 5:22 dining room, seated noted to have significant light brown fuzzher nose and down had a few longer, comouth, several shofew long gray chin his significant short, cohairs under bottom  On 6/06/17, at 2:11 self-propelling down and continued to have some conti	p.m. R51 was observed in the din her wheelchair. R51 was ficant facial hair. R51 had gray by hair which went from under the sides of her mouth. R51 coarse hairs near corners of the gray hairs under chin, a nairs under her chin and arse, light brown and gray lip in the crease of her chin.  p.m. R51 was observed in the hallway in her wheelchair ave significant facial hair.  9 p.m. R51 was observed in ated in a regular chair and significant facial hair.  00 p.m. nursing assistant was very confused and assist with ADLs. NA-G stated actice was female residents eded which was about every 3 residents had their own razors awer. She stated it was R51's R51 should have been		will be educated by July 17, 2017. medical director will be updated or policy changes on July 11, 2017. Director of Nursing will complete raudits of all residents for shaving to ensure policy is being followed. will be discussed at QA committee meetings quarterly to ensure compared to ensure compared to ensure the policy is being followed.	n final The andom choices Results	
	On 6/07/17, at 1:50 p.m. NA-C stated R51 was confused and required extensive assistance with					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				B) DATE SURVEY COMPLETED	
00444		B. WING	WING 06		06/08/2017		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
ST WILL	IAMS LIVING CENTE	R	SOO STRE	-			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	OULD BE COMPLETE		
2 850	ADLs. NA-C stated morning cares that unaware R51 had f should be shaved e hair removal. NA-C and that R51 did no room. NA-C stated and she should have today.  On 6/07/17, at 2:00 provided R51 a bat doesn't keep perso sanitary reasons. Sfor R51 should have and shaved her this on 6/08/17, at 11:0 confirmed R51 had stated she wasn't slast. She stated she facial hair anytime to residents looked nice. A policy related to gliving (ADLs) was renot have a specific SUGGESTED MET The director of nursimplement policies ensuring staff proviservices for resider policies. The quality committee could peensure compliance	she assisted R51 with her morning and stated she was acial hair. She stated R51 every day if she needed facial confirmed R51's facial hair of have a personal razor in her R51 needed to be shaved, we been shaved with her bath as p.m. NA-D stated she had razors in the tub room for he stated the NA who cared e used R51's personal razor is morning.  8 a.m. nurse manager (NM-A) never had her own razor, and ure when R51 was shaved expected staff to remove they notice it and expected all ce.  9 grooming and activities of daily equested. DON stated they did policy related to these.  THOD FOR CORRECTION: sing (DON) or designee could and procedures related to de the necessary grooming its and educate staff on these or assessment and assurance erform random audits to	2 850				
	TIME PERIOD FOR CORRECTION: Twenty (21)						

Minnesota Department of Health STATE FORM

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMP	LETED	
00444		B. WING		06/08/2017		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ST WILL	IAMS LIVING CENTE	212 WES	T SOO STRE S PRAIRIE, N	ET, BOX 30		
(VA) ID	CLIMMADV CTA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTI	ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 850	Continued From pa	ge 27	2 850			
	days.					

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