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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: P04Q

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00444

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

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

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

4. TYPE OF ACTION: **7** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/20/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

Effective June 14, 2017, the five layaway nursing home beds are permanently decertified in accordance with the permanent delicensure of these same five beds. Effective June 14, 2017, the number of certified SNF/NF beds are 53.

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 07/20/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Enforcement Specialist 08/21/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/03/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

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,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
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

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

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,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
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
cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

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,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: P04Q

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00444

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(L1) **245588**
2.STATE VENDOR OR MEDICAID NO.
(L2) **887342900**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/08/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Beth Nowling, HFE NEII 07/10/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/03/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

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: 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:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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

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

DEPARTMENT CONTACT

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

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

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

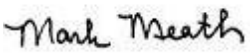
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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

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

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245588	A. BUILDING _____ B. WING _____	06/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 221 SS=D	483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must-	F 221		7/17/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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 other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245588	A. BUILDING _____ B. WING _____	06/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 1 (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the use of a self-releasing alarm belt (SRAB), (which alerted staff of attempted wheelchair exits) was not used as a physical restraint for 1 of 1 residents (R51) reviewed for restraints. Findings include: Review of R51's annual Minimum Data Set (MDS) dated 4/19/17, identified R51 had diagnoses which included dementia and arthritis. The MDS further identified R51 had severe cognitive impairment and required extensive assistance with all activities of daily living (ADL's) except for eating. The MDS indicated R51 had no physical restraints. R51's Care Area Assessment (CAA) dated 4/21/17, identified R51 had dementia, arthritis, pain and restricted mobility, and staff were to anticipate her needs and provide extensive assistance with ADL's. The CAA failed to identify the use of a SRAB for R51. R51'S care plan print dated 6/8/2017, identified R51 had impaired cognition and poor decision	F 221	For resident (R51) a Self Release Alarm Belt (SRAB) elimination/reduction is to be completed. If resident (R51) is not able to unable to remove the SRAB by herself by July 3, 2017, it will be assessed as a restraint. All residents with an SRAB will have reduction/elimination completed if applicable at least quarterly. Nurse will assure weekly that resident can remove the SRAB per self. If resident is not able to release belt per self, it will be assessed as a restraint per facility policy. The Self Release Alarm Belt Policy, Alarm Reduction Policy, Restraint Assessment, and Self Release Alarm Belt Assessment were reviewed and updated prior to July 3, 2017. Nursing staff will be educated at nurses meeting July 12, 2017 and all other staff will be educated by July 17, 2017. The medical director will be updated on final policy changes on July 11, 2017. The Director of Nursing will complete random audits of all residents that have SRAB to	

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	245588	A. BUILDING _____ B. WING _____	06/08/2017

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F 221	Continued From page 2 making skills. The care plan further identified R51 required extensive assistance with ADL's, and staff were to anticipate her needs to maintain R51's safety and comfort. The care plan indicated R51 would release her SRAB to alert staff when she had to use the bathroom or wanted to transfer into bed. The care plan indicated R51 may sit in a regular dining room chair at meals and activities without an alarm, and it was ok not to release the SRAB at meals due to R51 leaving the dining room quickly and was a fall risk. Review of R51's Self Release Belt Assessment dated 4/13/17, identified R51 was disoriented and had arthritis. The assessment further identified R51 was educated on the reason for the SRAB, was taught how the SRAB worked and was able to release it on her own. On 6/05/17, from 5:23 to 5:43 p.m. R51 was seated in the dining room in her wheelchair at the table for the supper meal. The dining room was full of residents as staff served meals and provided assistance to other residents at their tables. R51 wore a blue Velcro lap belt which had a white plastic hook and loop closure which closed around R51's waist and sides of her wheelchair. R51 sat at the table with other residents and ate her meal independently. On 6/07/17, at 1:50 p.m. R51 was seated in her wheelchair in front of the nurse's station. R51 wore a blue Velcro lap belt which had a white plastic hook and loop closure which was closed around R51's waist and sides of her wheelchair. R51's hands were on her lap and both hands shook in a tremor and rubbed against the top of the belt and the white closure of the SRAB. Nursing assistant (NA)-C was also present at the	F 221	ensure policy is being followed. Results will be discussed at QA committee meetings quarterly to ensure compliance.	

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F 221	Continued From page 3 nurses station. During interview, NA-C stated R51 was confused and required extensive assistance with her ADL's. She stated R51 had worn the self-release alarm belt (SRAB) for a year or 2, and stated she thought R51 could release the belt herself. On 6/7/17, at 1:52 p.m. NA-C approached R51 with surveyor in front of the nurses station. NA-C asked R51 several times out loud to take her SRAB off while she demonstrated how to release it by opening her arms in a quick motion. R51 did not attempt to remove the SRAB. NA-C then wrote the words "take off your seat belt" on a piece of white paper and put up close to R51's face for her to read. R51 did not attempt to release the SRAB after written request. NA-C released R51's SRAB and demonstrated how to release the SRAB for R51. NA-C reapplied R51's SRAB and continued to act out the action of releasing the SRAB. R51 made no attempt to release her SRAB and just smiled, belly laughed and talked under her breath. On 6/08/17, at 9:37 a.m. NA-H stated R51 was confused and required extensive assistance with ADL's. NA-H stated she was not sure how long R51 had used the SRAB and stated it prevented R51 from self-transferring. She stated R51 could release the SRAB on her own when she had to use the bathroom right away, and stated it had been a couple weeks since she observed R51 release the SRAB on her own. She stated staff only removed it for meals, at night when she went to bed or when they put her in a regular chair. She stated R51 used the SRAB all the time when she's in her wheelchair, and R51 mostly liked to roam around the facility in her wheelchair.	F 221		

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F 221	Continued From page 4 On 6/08/17, at 9:43 a.m. NA-I stated R51 was cognitively impaired and required staff assistance with ADL's. She stated she wasn't sure how long R51 had used the SRAB. She stated she thought R51 could release the SRAB but she did not, and stated she had never seen R51 release the SRAB on her own. She stated staff released it when they take her to the bathroom and in the dining room. On 6/8/17, at 9:56 a.m. NA-J stated R51 was confused and required extensive assistance with her ADL's. She stated she thought R51 had the SRAB for about a year to prevent unsafe self-transfers. She stated R51 probably could not release the belt by herself, unless she had to use the bathroom immediately. She stated she thought the last time she observed R51 release the SRAB on her own was about a couple months ago. She stated the SRAB was released at mealtimes and when R51 was is in a regular chair. On 6/8/17, at 10:12 a.m. licensed practical nurse (LPN)-B stated R51 was confused and required assistance with all cares. She stated she thought R51 had the SRAB for more than a year, and stated it was to prevent R51 from getting up on her own. She stated she wasn't sure when R51 was last able to release the SRAB on her own. She stated they removed the SRAB when she was in bed and when staff assisted R51 with toileting. She said residents at the facility had to be able to remove the SRAB and demonstrate they could remove it on their own before the SRAB was applied. She stated if R51 couldn't get the SRAB off it was a restraint. On 6/08/17, at 11:08 a.m. nurse manager (NM)-A	F 221		

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F 221	Continued From page 5	F 221		

stated R51 was confused and required extensive assistance with ADL's. She stated R51 has had the SRAB since 7/10/14 after she had a fall with injury. She stated she was not aware R51 was unable to release the SRAB on her own, and stated she was not sure how long it had been since R51 was able to release the SRAB on her own. She stated they had never tried a reduction as they felt the SRAB was a safety device and not a physical restraint. She stated the staff released R51's SRAB in the dining room if she would allow them to transfer her into a regular dining room chair and when R51 was toileted.

On 6/8/17, at 11:10 a.m. NM-B joined the interview with NM-A and stated she was unaware R51 could not release her SRAB on command and stated she felt R51 was able to remove her SRAB in the past.

NM-B confirmed R51's last assessment for the SRAB was completed 4/13/17 and it identified R51 was able to release the SRAB on her own. She stated if R51 could not release the SRAB on her own it would be a physical restraint. She confirmed the SRAB was assessed quarterly and they did not monitor R51's ability to remove the SRAB on her own in between assessments.

On 6/08/17, at 1:23 p.m. director of nurses (DON) stated the facility did not see the belt as a physical restraint for R51 because she thought R51 could release it if she wanted to. She stated R51 may not be have been able to release the SRAB on command because of her dementia. DON stated if R51 was unable to remove her SRAB on her own, it was a physical restraint.

Review of the facility policy Assessments and

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F 221	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.	F 221		
F 282 SS=D	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). Review of the nursing assistant (NA) daily care	F 282	Resident R66 now has nurse follow up on Treatment Administration Record (TAR) to 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 will chart refusals in resident's record after educating on risks/benefits of compressions stockings. Nursing staff will be educated at nurses	7/17/17

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F 282	Continued From page 7 sheet dated 6/8/17, identified R66 was to use knee high/thigh high compression stockings, on every morning and off at bedtime. On 6/05/17, at 4:33 p.m. R66 was seated in his room in his wheelchair, both feet rested on the floor. R66's ankles up to his calves were swollen and had significant indentations around the circumference of both calves from where the elastic band on the top of his regular white socks ended. R66 was not wearing compression stockings on either leg. He stated he required assistance to apply the compression stockings and staff were supposed to put on his compression socks in the morning and take them off at night before he went to bed. R66 stated the compression socks were ordered to reduce swelling and pain in his legs. He stated he felt some staff were absent minded and forgot to put them on and take them off. He stated in the past he had laid out his compression socks on the floor in his doorway to get staff's attention so they would get the hint to put them on. He stated the compression socks kept the swelling down in his legs. On 6/06/17, at 2:35 p.m. R66 was in his room seated in his wheelchair with regular black socks on both feet and was not wearing compression socks to either leg. R66 had deep indentations around his mid calves where the elastic from the top of his socks were. R66 stated he should not wear these socks because they were too tight, and his legs swelled up quickly without the compression socks on. He stated staff were supposed to put the compression socks on every day and indicated staff did not consistently apply or remove his compression socks. R66 stated he had not worn his compression socks for 2 days	F 282	meeting July 12, 2017 and all other staff will be educated by July 17, 2017. The medical director will be updated on final policy changes on July 11, 2017. The Director of Nursing will complete random audits of all residents that have compression stockings to ensure policy is being followed. Results will be discussed at QA committee meetings quarterly to ensure compliance.	

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because staff had not offered to assist with applying the compression stockings. He stated when staff do put his compression socks they sometimes forgot to take them off and then in the morning his legs were uncomfortable. He stated he felt there is a few staff he could can rely on and a lot he could not rely on. He stated he did not want to complain because he felt that made enemies and he did not want to use his call light because it aggravated the staff.

On 6/06/17, at 3:14 p.m. NA-E stated R66 required assistance to apply his compression socks. She stated the staff usually tried to put them on every day, and stated some days R66 refused. She stated when R66 refused they would usually let the nurse know and she could usually convince him to put them on. She stated she thought R66 always had edema in his legs.

On 6/06/17, at 3:22 p.m. NA-K stated he felt R66 needed help with his compression socks. He stated either the nurse or the NA's applied R66's compression socks and R66 was supposed to wear them every day. He stated R66 did not refuse to wear the compression socks and was willing to let him put the compression stockings on. He stated R66's legs were huge without the compression socks and R66 had told him the compression socks helped a lot with his swelling.

On 6/6/17, at 3:32 p.m. registered nurse (RN)-A stated R66 required staff's assistance with applying and removing his compression socks. RN-A indicated R66 occasionally refused to wear the compression socks, however; he did not have a pattern of refusing and they had not notified his physician of any refusals. She confirmed R66's current order for the compression socks and

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stated she expected the NA's to put them on every morning and take them off every night. She stated R66 had a lot of edema,which varied from day to day.

On 6/6/17, at 3:35 p.m. RN-A and surveyor entered R66's room. R66 was seated in his recliner with his feet elevated on the foot rests and wore regular black socks on both feet. R66 had both socks pushed down around his ankles and was not wearing his compression socks to either leg. RN-A confirmed R66 did not have his compression socks on either leg, and stated staff should have put them on this morning. RN asked R66, "Why aren't you wearing your compression socks?" R66 replied the staff forgot and I did not want to complain because it aggravated people.

On 6/07/17, at 7:16 a.m. NA-G stated R66 required assistance with applying his compression socks. She stated R66 was thankful and cooperative when staff helped put his compression socks on. She stated the NA's were responsible to apply R66 compression socks and document when they put them on and took them off. She stated R66 got up on his own in the morning and should have assistance with applying his compression socks before breakfast. She stated R66's swelling in his legs was better as long as he wore his compression socks, and stated she felt they helped to reduce R66's swelling.

On 6/08/17, at 10:28 a.m. nurse manager (NM-A) confirmed R66 had a current physician's order for compression socks for chronic swelling in his legs from arthritis. She stated she expected staff to apply R66's compression stockings every morning and take them off at bedtime as directed

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F 282	Continued From page 10 by the care plan. She stated R66 required help with the application and removal of his compression socks. She confirmed the documentation of R66's compression socks and stated she questioned the accuracy of the documentation, as she thought he refused to wear them more than the documentation revealed. 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. 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.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 309		7/17/17

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F 309	Continued From page 11 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and document review, the facility failed to apply therapeutic compression stockings (designed to help relieve swelling and aching) as ordered by the physician for 1 of 1 residents (R66) reviewed for localized edema. Findings include: Review of R66's current physician orders dated 5/16/17, revealed an order started 3/12/17, for knee high gradient pressure stockings to be placed on in the morning and off in the evening. R66's admission Minimum Data Set (MDS) dated 3/19/17 identified R66 had diagnoses which included arthritis, pain, weakness and localized	F 309	Resident R66 now has nurse follow up on Treatment Administration Record (TAR) to 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 will chart refusals in resident's record after educating on risks/benefits of compressions stockings.	

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F 309	Continued From page 12 edema. The MDS further identified R66 was cognitively intact and was independent with all activities of daily living (ADL's) except toileting. Review of R66's Care Area Assessment (CAA) dated 3/20/17, identified R66 had weakness, limited range of motion, poor coordination and balance, arthritis pain and cognitive impairment with changing cognitive status. The CAA further indicated R66 required physical assistance with dressing and failed to identify R66 had edema or required compression socks. 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). Review of the nursing assistant (NA) daily care sheet dated 6/8/17, identified R66 was to use knee high/thigh high compression stockings, on every morning and off at bedtime. Review of R66's medication administration record and treatment administration record from 3/1/17 to 6/8/2017 lacked monitoring for use of R66's compression stockings or swelling. On 6/05/17, at 4:33 p.m. R66 was seated in his room in his wheelchair, both feet rested on the floor. R66's ankles up to his calves were swollen and had significant indentations around the circumference of both calves from where the elastic band on the top of his regular white socks ended. R66 was not wearing compression	F 309	Nursing staff will be educated at nurses meeting July 12, 2017 and all other staff will be educated by July 17, 2017. The medical director will be updated on final policy changes on July 11, 2017. The Director of Nursing will complete random audits of all residents that have compression stockings to ensure policy is being followed. Results will be discussed at QA committee meetings quarterly to ensure compliance.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 13 stockings on either leg. He stated he required assistance to apply the compression stockings and staff were supposed to put on his compression socks in the morning and take them off at night before he went to bed. R66 stated the compression socks were ordered to reduce swelling and pain in his legs. He stated he felt some staff were absent minded and forgot to put them on and take them off. He stated in the past he had laid out his compression socks on the floor in his doorway to get staff's attention so they would get the hint to put them on. He stated the compression socks kept the swelling down in his legs. On 6/06/17, at 2:35 p.m. R66 was in his room seated in his wheelchair with regular black socks on both feet and was not wearing compression socks to either leg. R66 had deep indentations around his mid calves where the elastic from the top of his socks were. R66 stated he should not wear these socks because they were too tight, and his legs swelled up quickly without the compression socks on. He stated staff were supposed to put the compression socks on every day and indicated staff did not consistently apply or remove his compression socks. R66 stated he had not worn his compression socks for 2 days because staff had not offered to assist with applying the compression stockings. He stated when staff do put his compression socks they sometimes forgot to take them off and then in the morning his legs were uncomfortable. He stated he felt there is a few staff he could can rely on and a lot he could not rely on. He stated he did not want to complain because he felt that made enemies and he did not want to use his call light because it aggravated the staff.	F 309		

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F 309	Continued From page 14 On 6/06/17, at 3:03 p.m. NA-F confirmed R66 required extensive assistance to apply and remove his compression socks. She stated the NA's were responsible to put them on and take them off every day. On 6/06/17, at 3:14 p.m. NA-E stated R66 required assistance to apply his compression socks. She stated the staff usually tried to put them on every day, and stated some days R66 refused. She stated when R66 refused they would usually let the nurse know and she could usually convince him to put them on. She stated she thought R66 always had edema in his legs. On 6/06/17, at 3:22 p.m. NA-K stated he felt R66 needed help with his compression socks. He stated either the nurse or the NA's applied R66's compression socks and R66 was supposed to wear them every day. He stated R66 did not refuse to wear the compression socks and was willing to let him put the compression stockings on. He stated R66's legs were huge without the compression socks and R66 had told him the compression socks helped a lot with his swelling. On 6/6/17, at 3:32 p.m. registered nurse (RN)-A stated R66 required staff's assistance with applying and removing his compression socks. RN-A indicated R66 occasionally refused to wear the compression socks, however; he did not have a pattern of refusing and they had not notified his physician of any refusals. She confirmed R66's current order for the compression socks and stated she expected the NA's to put them on every morning and take them off every night. She stated R66 had a lot of edema,which varied from day to day.	F 309		

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F 309	Continued From page 15 On 6/6/17, at 3:35 p.m. RN-A and surveyor entered R66's room. R66 was seated in his recliner with his feet elevated on the foot rests and wore regular black socks on both feet. R66 had both socks pushed down around his ankles and was not wearing his compression socks to either leg. RN-A confirmed R66 did not have his compression socks on either leg, and stated staff should have put them on this morning. RN asked R66, "Why aren't you wearing your compression socks?" R66 replied the staff forgot and I did not want to complain because it aggravated people. On 6/07/17, at 7:16 a.m. NA-G stated R66 required assistance with applying his compression socks. She stated R66 was thankful and cooperative when staff helped put his compression socks on. She stated the NA's were responsible to apply R66 compression socks and document when they put them on and took them off. She stated R66 got up on his own in the morning and should have assistance with applying his compression socks before breakfast. She stated R66's swelling in his legs was better as long as he wore his compression socks, and stated she felt they helped to reduce R66's swelling. On 6/08/17, at 10:28 a.m. nurse manager (NM-A) confirmed R66 had a current physician's order for compression socks for chronic swelling in his legs from arthritis. She stated she expected staff to apply R66's compression stockings every morning and take them off at bedtime as directed by the care plan. She stated R66 required help with the application and removal of his compression socks. She confirmed the documentation of R66's compression socks and stated she questioned the accuracy of the	F 309		

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documentation, as she thought he refused to wear them more than the documentation revealed.

On 6/08/2017, at 1:04 p.m. during follow-up interview NM-A stated the NA's were responsible for applying R66's compression socks and documented refusals in the computer. She stated if the documentation identified several refusals for multiple days she would address it with the physician. She stated she had not personally updated the physician with any refusals, and stated there was not documentation of risk and benefit education for R66 when he refused to wear the compression socks. She stated the compression socks were a necessary treatment for R66's pain and swelling in his legs.

Review of R66's on and off schedule for JOBST socks from 3/12/17 to 6/8/17 revealed:

3/12/17-3/31/17, R66 had his compression socks applied every morning and removed every night with the exception of
5 days.

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

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F 309	Continued From page 17 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 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.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 312		7/17/17

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F 312	Continued From page 18 services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide grooming services related to the removal of facial hair for 1 of 1 residents (R51) observed to have significant facial hair. Findings include: Review of R51's annual Minimum Data Set (MDS) dated 4/19/17, identified R51 had diagnoses which included dementia, arthritis and pain. The MDS further identified R51 had severe cognitive impairment and required extensive assistance with all activities of daily living (ADLs) except for eating. R51's Care Area Assessment (CAA) dated 4/21/17, identified R51 had dementia, arthritis and restricted mobility. The CAA further identified staff were to anticipate R51's needs and provide extensive assistance with R51's ADLs. Review of R51's care plan dated 10/29/14, identified R51 required extensive assistant of 1 staff for grooming and R51 was to be neat and clean. On 6/05/17, at 5:22 p.m. R51 was observed in the dining room, seated in her wheelchair. R51 was noted to have significant facial hair. R51 had gray and light brown fuzzy hair which went from under her nose and down the sides of her mouth. R51 had a few longer, coarse hairs near corners of mouth, several shorter gray hairs under chin, a few long gray chin hairs under her chin and	F 312	Resident R51's daughter was called and electric shaver was brought to facility by family for resident's use. The resident was shaved by staff on June 10, 2017. All residents were asked if they wanted to be shaved. Any residents that did not want to be shaved had this information added to their care plan/Kardex. Those who wanted to be shaved were audited to see if they had their own shaver, if not family was contacted to bring in a shaver for them. The Shaving Policy was reviewed and updated on June 21, 2017. Social Services will ask upon admission if resident wants to be shaved. If resident does not want to be shaved, the information will be added to their care plan. If the resident does want to be shaved, an electric razor will be brought in by resident or family. Nursing staff will be educated at nurses meeting July 12, 2017 and all other staff will be educated by July 17, 2017. The medical director will be updated on final policy changes on July 11, 2017. The Director of Nursing will complete random audits of all residents for shaving choices to ensure policy is being followed. Results will be discussed at QA committee meetings quarterly to ensure compliance.	

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significant short, coarse, light brown and gray hairs under bottom lip in the crease of her chin.

On 6/06/17, at 2:11 p.m. R51 was observed self-propelling down the hallway in her wheelchair and continued to have significant facial hair.

On 6/07/17, at 12:39 p.m. R51 was observed in the dining room seated in a regular chair and continued to have significant facial hair.

On 6/07/17, at 12:00 p.m. nursing assistant (NA)-G stated R51 was very confused and required extensive assist with ADLs. NA-G stated the usual facility practice was female residents were shaved as needed which was about every 3 weeks. She stated residents had their own razors in their bedroom drawer. She stated it was R51's bath day today and R51 should have been shaved today if she needed it.

On 6/07/17, at 12:14 p.m. licensed practical nurse (LPN)-A stated R51 got confused at times and required extensive assistance with ADLs. She stated the usual facility practice was female residents were shaved every week with their bath. She stated R51 should have been shaved today with her bath.

On 6/07/17, at 1:50 p.m. NA-C stated R51 was confused and required extensive assistance with ADLs. NA-C stated she assisted R51 with her morning cares that morning and stated she was unaware R51 had facial hair. She stated R51 should be shaved every day if she needed facial hair removal. NA-C confirmed R51's facial hair and that R51 did not have a personal razor in her room. NA-C stated R51 needed to be shaved, and she should have been shaved with her bath

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F 312	Continued From page 20 today. On 6/07/17, at 2:03 p.m. NA-D stated she provided R51 a bath today, and stated she doesn't keep personal razors in the tub room for sanitary reasons. She stated the NA who cared for R51 should have used R51's personal razor and shaved her this morning. On 6/08/17, at 11:08 a.m. nurse manager (NM-A) confirmed R51 had never had her own razor, and stated she wasn't sure when R51 was shaved last. She stated she expected staff to remove facial hair anytime they notice it and expected all residents looked nice. A policy related to grooming and activities of daily living (ADLs) was requested. DON stated they did not have a specific policy related to these.	F 312		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F 323		7/17/17

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F 323	Continued From page 21 (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure consistent implementation of a smoking apron to prevent injury for 1 of 1 residents (R28) reviewed who required a smoking apron for safety. R28's significant change Minimum Data Set (MDS) dated 11/1/16, identified R28 had moderate cognitive impairment and diagnoses which included dementia, epilepsy, chronic obstructive pulmonary disease (COPD) and anxiety. The MDS identified R28 required extensive assistance with areas of daily living (ADL's,) including ambulation and locomotion. The MDS did not identify whether R28 used tobacco products. R28's quarterly MDS dated 4/19/17, identified R28 had severe cognitive impairment and had diagnoses which included dementia, epilepsy, COPD and anxiety. The MDS identified R28 continued to required extensive assistance with ADL's. The MDS did not identify whether R28 used tobacco products. R28's smoking assessment dated 11/3/16,	F 323	Resident R28 had a smoking assessment 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 to 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 resident needs. Nursing staff will be educated at nurses meeting July 12, 2017 and all other staff will be educated by July 17, 2017. The medical director will be updated on final policy changes on July 11, 2017. The Director of Nursing will complete random audits of the to ensure that assessments and care plans are being completed per the facility policy and resident needs.	

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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. R28's care plan revised 1/26/17, identified R28 was a current active smoker. The care plan identified various intervention for R28's smoking safety which included; no oxygen use when smoking, staff to store, distribute R28's smoking materials, light tobacco products, staff to monitor resident's safety during smoking. R28's care plan identified staff could stand inside the facility door, with R28 in sight while he smoked. On 6/05/2017, at 4:51 p.m. trained medical assistant (TMA)-A entered the medication room and obtained a cigarette and lighter per R28's request. TMA-A walked with R28 as she propelled her wheel chair through a small foyer and out to the smoking patio. Both R28 and TMA-A passed by two white colored smoking aprons hanging by hooks on the wall of the small foyer, however; did not obtain a smoking apron. TMA-A handed R28 the cigarette and ignited the lighter for R28 to light her cigarette. TMA-A sat on cement blocks surrounding the flower garden facing R28. R28 independently handled the cigarette, smoked, placed the ash and extinguished the cigarette in the provided metal receptacle. Although R28's smoking assessment dated 11/3/16, identified the need for use of a smoking apron R28 did not wear a smoking apron nor was one offered to her.	F 323	Results will be discussed at QA committee meetings quarterly to ensure compliance.	

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F 323	Continued From page 23 On 6/06/2017, at 9:40 a.m. R28 was seated in a wheelchair outside the facility with activities director (AD)-A who was seated in a chair against the outside wall of the facility on the smoking patio. R28 did not have a smoking apron on. R28 was seated in the wheelchair next to the smoking receptacle with her back to AD-A. R28 independently smoked, disposed of ashes and extinguished the cigarette. On 6/05/2017, at 5:03 p.m.. TMA-A stated R28 required staff assistance to light the cigarette and needed facility staff to sit with her while she smoked. TMA-A indicated R28 had an assessment and care plan for smoking and was not aware R28 needed to use a smoking apron. On 6/06/2017, at 9:44 a.m. AD-A indicated when R28 requested a cigarette any available staff could sit with R28 on the smoking patio and watch her while she smoked. AD-A indicated a cigarette and lighter were obtained from nursing staff. Staff would light the cigarette for R28 and sit with her while she smoked. AD-A indicated R28 had poor short term memory and requested to smoke often. AD-A indicated R28 may request a cigarette right after smoking one because of her poor memory. On 6/06/2017, at 1:52 p.m. nursing assistant (NA)-A indicated any facility staff could assist R28 to smoke. NA-A stated staff would obtain the smoking materials from the nurses station, a smoking apron was retrieved from a hook which hung on the wall in the foyer. NA-A indicated staff would apply the smoking apron, light the cigarette and sit with R28 until she finished. NA-A stated	F 323		

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F 323	Continued From page 24 the smoking apron was used so R28 would not burned. On 6/06/2017, at 2:02 p.m. NA-B indicated R28's cigarette and lighter were locked in the medication room. NA-B indicated staff would get the smoking materials from a nurse, take R28 outside, place a smoking apron on R28, light the cigarette and stay with R28 until she was finished smoking. NA-B indicated the smoking apron was used in case R28 dropped ashes on herself. NA-B verified he/she had not seen R28 drop a cigarette on herself but had witnessed her drop plenty of ashes. On 6/06/2017, at 2:35 p.m. R28 was seated in a wheel chair on the smoking patio. R28 wore a white smoking apron which covered her chest and lap. Activity aid (AA)-A sat and visited with R28 as she independently smoked the cigarette. At 2:51 p.m. AA-A removed R28's smoking apron placed it on the hook on the wall in the foyer and assisted R28 into the building. On 6/06/2017, at 2:53 p.m. AA-A indicated nursing staff would find AA-A and request he/she sit with R28 while she smoked. AA-A indicated smoking materials were retrieved from the medication room, a smoking apron would be placed on R28 so that she would not burn herself and staff would then sit and visit until R28 is finished smoking. On 6/06/2017, at 3:16 p.m. R28's medical record was reviewed with nurse manager (NM)-A. NM-A confirmed the most recent smoking	F 323		

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F 323	Continued From page 25	F 323		

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 facility practice was for each resident care be provided as directed by the assessment findings. NM-A indicated when an 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 nursing (DON) indicted the facility protocol was to perform an initial smoking assessments upon admission and then quarterly or with a change in status. The DON verified all smoking assessments were completed in the computer system. With review of R28's medical record, the DON verified R28's last smoking assessment was completed 11/3/16, and one should have been completed in February 2017. The DON indicated being unaware of a change in R28's cognition or physical condition, however; assumed if the care plan was changed to discontinue the use of the smoking apron, an assessment should have been completed. The DON further indicated R28 had previously used a smoking apron, though felt R28 no longer required one.

On 6/06/2017, 4:07 P.M. NM-B indicated being responsible for discontinuing the use of the smoking apron from R28's care plan. NM-B verified the most current smoking assessment was dated 11/3/16, and it indicated a smoking apron was to be utilized in order to ensure safety with smoking for R28. NM-B indicated the usual practice was to complete an assessment,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245588	A. BUILDING _____ B. WING _____	06/08/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 26 document the findings in the residents progress notes and then to change the care plan if needed. NM-B verified neither an assessment nor a progress note regarding R28's smoking ability was found with review of R28's computerized chart past 11/3/16. 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.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245588	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/06/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. Williams Living Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Health Care Facilities Code, NFPA 99 PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	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 other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245588	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/06/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The facility was inspected as two separate buildings: St. Williams Living Center is a 1-story building with no basement. The building was constructed at 6 different times. The original building was constructed in 1963 and was determined to be type II(000) construction. In 1967 an addition was added to the south that was determined to be of Type II(111) construction. In 1976 an addition was added to the west that was determined to be of Type II(111) construction. In 1996 additions were added to the northwest that was determined to be of Type V(111) construction. In 2001 an addition was added to the northeast that was	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245588	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/06/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 determined to be of Type V(111) construction. In 2007 an addition was added to the southeast that was determined to be of Type II(111) Construction. The building is fully fire sprinklered throughout. The facility has a fire alarm system that includes smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 53 beds and had a census of 51 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 133 SS=E	NFPA 101 Multiple Occupancies - Construction Type Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the protective opening rating in two 2 hour fire barriers as listed in the	K 133	1) The one inch diameter hole in the 2-hour fire barrier above the cross corridor doors at the 1996 building was filled with	6/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245588	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/06/2017**

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

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K 133	Continued From page 3 Life Safety Code NFPA 101 2012 edition, table 8.3.4.2. This deficient practice could cause fire to spread more quickly through a compartment and affect an undetermined amount of residents, staff and visitors. Findings include: 1) At 10:01 am on 06/06/17 observations revealed, a one inch diameter hole in the 2 hour fire barrier above the cross corridor doors at the 1996 addition. 2) At 10:11am on 06/06/17 observations revealed one 3"x8" and one 2"x4" penetration above the ceiling line of the 2 hour fire barrier at the chapel link. This deficient condition was confirmed by the Facility Administrator and the Maintenance Director	K 133	sheetrock and 3M CP 25WB+ Fire Barrier Sealant. 2) The 3"x8" and 2"x4" penetrations above the ceiling line of the 2-hour fire barrier at the chapel link were filled with sheetrock and 3M CP 25WB+ Fire Barrier Sealant. The corrections were completed prior to June 29, 2017. The maintenance director and maintenance staff were responsible for the correction, and the correction was verified by the administrator. To monitor to prevent a reoccurrence of the deficiency the maintenance director will inspect to ensure that a 2-hour fire barrier is properly maintained after any penetrations are made from a contractor.	
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____	K 353		6/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245588	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/06/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 4 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could allow for the misinterpretation of the sprinkler systems capability to function properly and allow for the spread of fire. This could affect all of the 53 residents and an undetermined amount of staff and visitors. Findings include: At 9:10 am on 06/06/07 documentation review revealed there was no documentation of a sprinkler system obstruction inspection in the last 5 years. This deficient condition was confirmed by the Facility Administrator and the Maintenance Director	K 353	a) A five-year internal pipe inspection for the sprinkler system was completed on June 29, 2017. The sprinkler system inspection included obstruction inspections for all needed locations. b) This five-year internal pipe inspection was completed by Summit Companies. c) The water system supply source is the City of Parkers Prairie. The administrator and maintenance director were responsible for the correction and will assure that monitoring will occur to prevent reoccurrence of the deficiency by keeping documentation of the 5-year internal pipe inspection in maintenance director's fire documentation book.	
K 372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where	K 372		6/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245588	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/06/2017**

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K 372	Continued From page 5 an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain one of three smoke barriers as required by the 2012 Life Safety Code (NFPA 101) section 19.3.7.3, 8.8.7.1 (1). This deficient practice could allow smoke to transfer from one smoke compartment to another affecting the exiting of 11 of the 53 residents and an undetermined amount of staff and visitors. Findings include: At 10:34 am on 06/06/07 observations revealed the smoke barrier along the great room and dining room separation did not have the proper fire/smoke stopping along the top of the wall and in the wall penetrations of the joist bracing. This deficient condition was confirmed by the Facility Administrator and the Maintenance Director	K 372	Fire/smoke stopping was installed along the top of the wall and in the wall penetrations of the joist bracing at the smoke barrier along the great room and dining room separation. The maintenance director and maintenance staff installed Thermafiber Ultrabatt professional grade mineral wool at the above-named location. The installation was verified by the administrator. The corrections were completed prior to June 29, 2017. To monitor to prevent a reoccurrence of the deficiency the maintenance director and administrator will inspect to ensure that fire compartments are maintained, after any new construction is completed.	
K 711 SS=F	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2	K 711		7/3/17

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	245588	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/06/2017**

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

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K 711	Continued From page 6 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to maintain a Fire Safety Plan as required in NFPA 101 Life Safety Code, 2012 edition section 19.7.2.2. This deficient practice could cause confusion in an emergency and affect all 53 residents and an undetermined amount of staff and visitors. Findings include: At 8:45 am on 06/06/07 documentation review revealed the Fire Safety plan did not address all 9 items as specified in the Life Safety Code. This deficient condition was confirmed by the Facility Administrator and the Maintenance Director	K 711	St. William's Living Center's Fire & Evacuation Plan, which includes the Fire Safety Plan, was updated July 3, 2017 to address all 9 items from the NFPA 101 Life Safety Code, 2012 edition section 19.7.2.2. The plan was updated with the assistance of the Human Resources Director, Director of Nursing, Maintenance director, and Administrator. The team identified above is responsible monitoring Life Safety Code regulations and update the Fire Safety Plan as rules change. All St. William's Living Center staff will be educated on the changes to the Fire & Evacuation Plan by July 17, 2017.	

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	245588	A. BUILDING **02 - NEW BLDG** B. WING _____	**06/06/2017**

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

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K 000	INITIAL COMMENTS FIRE SAFETY 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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — 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 other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	245588	A. BUILDING **02 - NEW BLDG** B. WING _____	**06/06/2017**

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K 000	Continued From page 1 State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The facility was inspected as two separate buildings: St. Williams Living Center is a 1-story building with no basement. The building was constructed at 6 different times. The original building was constructed in 1963 and was determined to be type II(000) construction. In 1967 an addition was added to the south that was determined to be of Type II(111) construction. In 1976 an addition was added to the west that was determined to be of Type II(111) construction. In 1996 additions were added to the northwest that was determined to be of Type V(111) construction. In 2001 an addition was added to the northeast that was	K 000		

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

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K 000	Continued From page 2 determined to be of Type V(111) construction. In 2007 an addition was added to the southeast that was determined to be of Type II(111) Construction. The building is fully fire sprinklered throughout. The facility has a fire alarm system that includes smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 53 beds and had a census of 51 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 133 SS=E	NFPA 101 Multiple Occupancies - Construction Type Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the protective opening rating in two 2 hour fire barriers as listed in the	K 133	1) The one inch diameter hole in the 2-hour fire barrier above the cross corridor doors at the 1996 building was filled with	6/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 133	Continued From page 3 Life Safety Code NFPA 101 2012 edition, table 8.3.4.2. This deficient practice could cause fire to spread more quickly through a compartment and affect an undetermined amount of residents, staff and visitors. Findings include: 1) At 10:01 am on 06/06/17 observations revealed, a one inch diameter hole in the 2 hour fire barrier above the cross corridor doors of the 1996 addition. 2) At 10:11am on 06/06/17 observations revealed one 3"x8" and one 2"x4" penetration above the ceiling line of the 2 hour fire barrier at the chapel link. This deficient condition was confirmed by the Facility Administrator and the Maintenance Director	K 133	sheetrock and 3M CP 25WB+ Fire Barrier Sealant. 2) The 3"x8" and 2"x4" penetrations above the ceiling line of the 2-hour fire barrier at the chapel link were filled with sheetrock and 3M CP 25WB+ Fire Barrier Sealant. The corrections were completed prior to June 29, 2017. The maintenance director and maintenance staff were responsible for the correction, and the correction was verified by the administrator. To monitor to prevent a reoccurrence of the deficiency, the maintenance director will inspect to ensure that a 2-hour fire barrier is properly maintained after any penetrations are made from a contractor.	
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____	K 353		6/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245588	A. BUILDING **02 - NEW BLDG** B. WING _____	**06/06/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 4 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on documentatjion review and staff interview, the facility failed to test and maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could allow for the misinterpretation of the sprinkler systems capability to function properly and allow for the spread of fire. This could affect all of the 53 residents and an undetermined amount of staff and visitors. Findings include: At 9:10 am on 06/06/07 documentation review revealed there was no documentation of a sprinkler system obstruction inspection in the last 5 years. This deficient condition was confirmed by the Facility Administrator and the Maintenance Director	K 353	a) A five-year internal pipe inspection for the sprinkler system was completed on June 29, 2017. The sprinkler system inspection included obstruction inspections for all needed locations. b) This five-year internal pipe inspection was completed by Summit Companies. c) The water system supply source is the City of Parkers Prairie. The administrator and maintenance director were responsible for the correction and will assure that monitoring will occur to prevent reoccurrence of the deficiency by keeping documentation of the 5-year internal pipe inspection in maintenance director's fire documentation book.	
K 711 SS=F	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2	K 711		7/3/17

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K 711	Continued From page 5 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to maintain a Fire Safety Plan as required in NFPA 101 Life Safety Code, 2012 edition section 19.7.2.2. This deficient practice could cause confusion in an emergency and affect all 53 residents and an undetermined amount of staff and visitors. Findings include: At 8:45 am on 06/06/07 documentation review revealed the Fire Safety plan did not address all 9 items as specified in the Life Safety Code. This deficient condition was confirmed by the Facility Administrator and the Maintenance Director	K 711	St. William's Living Center's Fire & Evacuation Plan, which includes the Fire Safety Plan, was updated July 3, 2017 to address all 9 items from the NFPA 101 Life Safety Code, 2012 edition section 19.7.2.2. The plan was updated with the assistance of the Human Resources Director, Director of Nursing, Maintenance director, and Administrator. The team identified above is responsible monitoring Life Safety Code regulations and update the Fire Safety Plan as rules change. All St. William's Living Center staff will be educated on the changes to the Fire & Evacuation Plan by July 17, 2017.	

MDH
Minnesota Department of Health

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00444	A. BUILDING: _____ B. WING _____	06/08/2017

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On June 5, 6, 7 and 8th, 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 510	MN Rule 4658.0300 Subp. 2 Use of Restraints Subp. 2. Freedom from restraints. Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the use of a self-releasing alarm belt (SRAB), (which alerted staff of attempted wheelchair exits) was not used as a physical restraint for 1 of 1 residents (R51) reviewed for restraints. Findings include: Review of R51's annual Minimum Data Set (MDS) dated 4/19/17, identified R51 had diagnoses which included dementia and arthritis. The MDS further identified R51 had severe cognitive impairment and required extensive assistance with all activities of daily living (ADL's) except for eating. The MDS indicated R51 had no physical restraints. R51's Care Area Assessment (CAA) dated 4/21/17, identified R51 had dementia, arthritis, pain and restricted mobility, and staff were to anticipate her needs and provide extensive assistance with ADL's. The CAA failed to identify	2 510	For resident (R51) a Self Release Alarm Belt (SRAB) elimination/reduction is to be completed. If resident (R51) is not able to unable to remove the SRAB by herself by July 3, 2017, it will be assessed as a restraint. All residents with an SRAB will have reduction/elimination completed if applicable at least quarterly. Nurse will assure weekly that resident can remove the SRAB per self. If resident is not able to release belt per self, it will be assessed as a restraint per facility policy. The Self Release Alarm Belt Policy, Alarm Reduction Policy, Restraint Assessment, and Self Release Alarm Belt Assessment were reviewed and updated prior to July 3, 2017. Nursing staff will be educated at nurses meeting July 12, 2017 and all other staff will be educated by July 17, 2017. The	7/17/17

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2 510	Continued From page 3 the use of a SRAB for R51. R51'S care plan print dated 6/8/2017, identified R51 had impaired cognition and poor decision making skills. The care plan further identified R51 required extensive assistance with ADL's, and staff were to anticipate her needs to maintain R51's safety and comfort. The care plan indicated R51 would release her SRAB to alert staff when she had to use the bathroom or wanted to transfer into bed. The care plan indicated R51 may sit in a regular dining room chair at meals and activities without an alarm, and it was ok not to release the SRAB at meals due to R51 leaving the dining room quickly and was a fall risk. Review of R51's Self Release Belt Assessment dated 4/13/17, identified R51 was disoriented and had arthritis. The assessment further identified R51 was educated on the reason for the SRAB, was taught how the SRAB worked and was able to release it on her own. On 6/05/17, from 5:23 to 5:43 p.m. R51 was seated in the dining room in her wheelchair at the table for the supper meal. The dining room was full of residents as staff served meals and provided assistance to other residents at their tables. R51 wore a blue Velcro lap belt which had a white plastic hook and loop closure which closed around R51's waist and sides of her wheelchair. R51 sat at the table with other residents and ate her meal independently. On 6/07/17, at 1:50 p.m. R51 was seated in her wheelchair in front of the nurse's station. R51 wore a blue Velcro lap belt which had a white plastic hook and loop closure which was closed around R51's waist and sides of her wheelchair. R51's hands were on her lap and both hands	2 510	medical director will be updated on final policy changes on July 11, 2017. The Director of Nursing will complete random audits of all residents that have SRAB to ensure policy is being followed. Results will be discussed at QA committee meetings quarterly to ensure compliance.	

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2 510	Continued From page 4 shook in a tremor and rubbed against the top of the belt and the white closure of the SRAB. Nursing assistant (NA)-C was also present at the nurses station. During interview, NA-C stated R51 was confused and required extensive assistance with her ADL's. She stated R51 had worn the self-release alarm belt (SRAB) for a year or 2, and stated she thought R51 could release the belt herself. On 6/7/17, at 1:52 p.m. NA-C approached R51 with surveyor in front of the nurses station. NA-C asked R51 several times out loud to take her SRAB off while she demonstrated how to release it by opening her arms in a quick motion. R51 did not attempt to remove the SRAB. NA-C then wrote the words "take off your seat belt" on a piece of white paper and put up close to R51's face for her to read. R51 did not attempt to release the SRAB after written request. NA-C released R51's SRAB and demonstrated how to release the SRAB for R51. NA-C reapplied R51's SRAB and continued to act out the action of releasing the SRAB. R51 made no attempt to release her SRAB and just smiled, belly laughed and talked under her breath. On 6/08/17, at 9:37 a.m. NA-H stated R51 was confused and required extensive assistance with ADL's. NA-H stated she was not sure how long R51 had used the SRAB and stated it prevented R51 from self-transferring. She stated R51 could release the SRAB on her own when she had to use the bathroom right away, and stated it had been a couple weeks since she observed R51 release the SRAB on her own. She stated staff only removed it for meals, at night when she went to bed or when they put her in a regular chair. She stated R51 used the SRAB all the time when she's in her wheelchair, and R51 mostly liked to	2 510		

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2 510	Continued From page 5 roam around the facility in her wheelchair. On 6/08/17, at 9:43 a.m. NA-I stated R51 was cognitively impaired and required staff assistance with ADL's. She stated she wasn't sure how long R51 had used the SRAB. She stated she thought R51 could release the SRAB but she did not, and stated she had never seen R51 release the SRAB on her own. She stated staff released it when they take her to the bathroom and in the dining room. On 6/8/17, at 9:56 a.m. NA-J stated R51 was confused and required extensive assistance with her ADL's. She stated she thought R51 had the SRAB for about a year to prevent unsafe self-transfers. She stated R51 probably could not release the belt by herself, unless she had to use the bathroom immediately. She stated she thought the last time she observed R51 release the SRAB on her own was about a couple months ago. She stated the SRAB was released at mealtimes and when R51 was is in a regular chair. On 6/8/17, at 10:12 a.m. licensed practical nurse (LPN)-B stated R51 was confused and required assistance with all cares. She stated she thought R51 had the SRAB for more than a year, and stated it was to prevent R51 from getting up on her own. She stated she wasn't sure when R51 was last able to release the SRAB on her own. She stated they removed the SRAB when she was in bed and when staff assisted R51 with toileting. She said residents at the facility had to be able to remove the SRAB and demonstrate they could remove it on their own before the SRAB was applied. She stated if R51 couldn't get the SRAB off it was a restraint.	2 510		

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2 510	Continued From page 6 On 6/08/17, at 11:08 a.m. nurse manager (NM)-A stated R51 was confused and required extensive assistance with ADL's. She stated R51 has had the SRAB since 7/10/14 after she had a fall with injury. She stated she was not aware R51 was unable to release the SRAB on her own, and stated she was not sure how long it had been since R51 was able to release the SRAB on her own. She stated they had never tried a reduction as they felt the SRAB was a safety device and not a physical restraint. She stated the staff released R51's SRAB in the dining room if she would allow them to transfer her into a regular dining room chair and when R51 was toileted. On 6/8/17, at 11:10 a.m. NM-B joined the interview with NM-A and stated she was unaware R51 could not release her SRAB on command and stated she felt R51 was able to remove her SRAB in the past. NM-B confirmed R51's last assessment for the SRAB was completed 4/13/17 and it identified R51 was able to release the SRAB on her own. She stated if R51 could not release the SRAB on her own it would be a physical restraint. She confirmed the SRAB was assessed quarterly and they did not monitor R51's ability to remove the SRAB on her own in between assessments. On 6/08/17, at 1:23 p.m. director of nurses (DON) stated the facility did not see the belt as a physical restraint for R51 because she thought R51 could release it if she wanted to. She stated R51 may not be have been able to release the SRAB on command because of her dementia. DON stated if R51 was unable to remove her SRAB on her own, it was a physical restraint. Review of the facility policy Assessments and	2 510		

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2 510	Continued From page 7 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. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could implement policies and procedures related to identification and assessment of physical restraints 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.	2 510		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN 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.	2 565	Resident R66 now has nurse follow up on Treatment Administration Record (TAR) to 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.	7/17/17

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 8 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). Review of the nursing assistant (NA) daily care sheet dated 6/8/17, identified R66 was to use knee high/thigh high compression stockings, on every morning and off at bedtime. On 6/05/17, at 4:33 p.m. R66 was seated in his room in his wheelchair, both feet rested on the floor. R66's ankles up to his calves were swollen and had significant indentations around the circumference of both calves from where the elastic band on the top of his regular white socks ended. R66 was not wearing compression stockings on either leg. He stated he required assistance to apply the compression stockings and staff were supposed to put on his compression socks in the morning and take them off at night before he went to bed. R66 stated the compression socks were ordered to reduce swelling and pain in his legs. He stated he felt some staff were absent minded and forgot to put them on and take them off. He stated in the past he had laid out his compression socks on the floor in his doorway to get staff's attention so they would get the hint to put them on. He stated the compression socks kept the swelling down in his legs. On 6/06/17, at 2:35 p.m. R66 was in his room seated in his wheelchair with regular black socks	2 565	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 will chart refusals in resident□s record after educating on risks/benefits of compressions stockings. Nursing staff will be educated at nurses meeting July 12, 2017 and all other staff will be educated by July 17, 2017. The medical director will be updated on final policy changes on July 11, 2017. The Director of Nursing will complete random audits of all residents that have compression stockings to ensure policy is being followed. Results will be discussed at QA committee meetings quarterly to ensure compliance.	

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2 565	Continued From page 9	2 565		

on both feet and was not wearing compression socks to either leg. R66 had deep indentations around his mid calves where the elastic from the top of his socks were. R66 stated he should not wear these socks because they were too tight, and his legs swelled up quickly without the compression socks on. He stated staff were supposed to put the compression socks on every day and indicated staff did not consistently apply or remove his compression socks. R66 stated he had not worn his compression socks for 2 days because staff had not offered to assist with applying the compression stockings. He stated when staff do put his compression socks they sometimes forgot to take them off and then in the morning his legs were uncomfortable. He stated he felt there is a few staff he could can rely on and a lot he could not rely on. He stated he did not want to complain because he felt that made enemies and he did not want to use his call light because it aggravated the staff.

On 6/06/17, at 3:14 p.m. NA-E stated R66 required assistance to apply his compression socks. She stated the staff usually tried to put them on every day, and stated some days R66 refused. She stated when R66 refused they would usually let the nurse know and she could usually convince him to put them on. She stated she thought R66 always had edema in his legs.

On 6/06/17, at 3:22 p.m. NA-K stated he felt R66 needed help with his compression socks. He stated either the nurse or the NA's applied R66's compression socks and R66 was supposed to wear them every day. He stated R66 did not refuse to wear the compression socks and was willing to let him put the compression stockings on. He stated R66's legs were huge without the compression socks and R66 had told him the

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2 565	Continued From page 10 compression socks helped a lot with his swelling. On 6/6/17, at 3:32 p.m. registered nurse (RN)-A stated R66 required staff's assistance with applying and removing his compression socks. RN-A indicated R66 occasionally refused to wear the compression socks, however; he did not have a pattern of refusing and they had not notified his physician of any refusals. She confirmed R66's current order for the compression socks and stated she expected the NA's to put them on every morning and take them off every night. She stated R66 had a lot of edema,which varied from day to day. On 6/6/17, at 3:35 p.m. RN-A and surveyor entered R66's room. R66 was seated in his recliner with his feet elevated on the foot rests and wore regular black socks on both feet. R66 had both socks pushed down around his ankles and was not wearing his compression socks to either leg. RN-A confirmed R66 did not have his compression socks on either leg, and stated staff should have put them on this morning. RN asked R66, "Why aren't you wearing your compression socks?" R66 replied the staff forgot and I did not want to complain because it aggravated people. On 6/07/17, at 7:16 a.m. NA-G stated R66 required assistance with applying his compression socks. She stated R66 was thankful and cooperative when staff helped put his compression socks on. She stated the NA's were responsible to apply R66 compression socks and document when they put them on and took them off. She stated R66 got up on his own in the morning and should have assistance with applying his compression socks before breakfast. She stated R66's swelling in his legs was better as long as he wore his compression socks, and	2 565		

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2 565	Continued From page 11 stated she felt they helped to reduce R66's swelling. On 6/08/17, at 10:28 a.m. nurse manager (NM-A) confirmed R66 had a current physician's order for compression socks for chronic swelling in his legs from arthritis. She stated she expected staff to apply R66's compression stockings every morning and take them off at bedtime as directed by the care plan. She stated R66 required help with the application and removal of his compression socks. She confirmed the documentation of R66's compression socks and stated she questioned the accuracy of the documentation, as she thought he refused to wear them more than the documentation revealed. 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. 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. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could implement policies and procedures related to ensuring staff implement resident care plans and educate staff on these policies. The quality assessment and assurance committee could perform random audits to ensure compliance.	2 565		

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2 565	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: F323 and F282 Based on observation, interview and document review the facility failed to ensure consistent implementation of a smoking apron to prevent injury for 1 of 1 residents (R28) reviewed who required a smoking apron for safety. In addition, the facility failed to ensure care plan interventions were followed for 1 of 1 resident for use of compression stockings. Findings include: R28's significant change Minimum Data Set (MDS) dated 11/1/16, identified R28 had moderate cognitive impairment and diagnoses	2 830	Resident R28 had a smoking assessment 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 to 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	7/17/17

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2 830	Continued From page 13 which included dementia, epilepsy, chronic obstructive pulmonary disease (COPD) and anxiety. The MDS identified R28 required extensive assistance with areas of daily living (ADL's,) including ambulation and locomotion. The MDS did not identify whether R28 used tobacco products. R28's quarterly MDS dated 4/19/17, identified R28 had severe cognitive impairment and had diagnoses which included dementia, epilepsy, COPD and anxiety. The MDS identified R28 continued to required extensive assistance with ADL's. The MDS did not identify whether R28 used tobacco products. R28's smoking assessment dated 11/3/16, 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. R28's care plan revised 1/26/17, identified R28 was a current active smoker. The care plan identified various intervention for R28's smoking safety which included; no oxygen use when smoking, staff to store, distribute R28's smoking materials, light tobacco products, staff to monitor resident's safety during smoking. R28's care plan identified staff could stand inside the facility door, with R28 in sight while he smoked. On 6/05/2017, at 4:51 p.m. trained medical assistant (TMA)-A entered the medication room and obtained a cigarette and lighter per R28's	2 830	resident needs. Nursing staff will be educated at nurses meeting July 12, 2017 and all other staff will be educated by July 17, 2017. The medical director will be updated on final policy changes on July 11, 2017. The Director of Nursing will complete random audits of the to ensure that assessments and care plans are being completed per the facility policy and resident needs. Results will be discussed at QA committee meetings quarterly to ensure compliance.	

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2 830	Continued From page 14 request. TMA-A walked with R28 as she propelled her wheel chair through a small foyer and out to the smoking patio. Both R28 and TMA-A passed by two white colored smoking aprons hanging by hooks on the wall of the small foyer, however; did not obtain a smoking apron. TMA-A handed R28 the cigarette and ignited the lighter for R28 to light her cigarette. TMA-A sat on cement blocks surrounding the flower garden facing R28. R28 independently handled the cigarette, smoked, placed the ash and extinguished the cigarette in the provided metal receptacle. Although R28's smoking assessment dated 11/3/16, identified the need for use of a smoking apron R28 did not wear a smoking apron nor was one offered to her. On 6/06/2017, at 9:40 a.m. R28 was seated in a wheelchair outside the facility with activities director (AD)-A who was seated in a chair against the outside wall of the facility on the smoking patio. R28 did not have a smoking apron on. R28 was seated in the wheelchair next to the smoking receptacle with her back to AD-A. R28 independently smoked, disposed of ashes and extinguished the cigarette. On 6/05/2017, at 5:03 p.m.. TMA-A stated R28 required staff assistance to light the cigarette and needed facility staff to sit with her while she smoked. TMA-A indicated R28 had an assessment and care plan for smoking and was not aware R28 needed to use a smoking apron. On 6/06/2017, at 9:44 a.m. AD-A indicated when R28 requested a cigarette any available staff could sit with R28 on the smoking patio and watch her while she smoked. AD-A indicated a cigarette and lighter were obtained from nursing staff. Staff would light the cigarette for R28 and sit	2 830		

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2 830	Continued From page 15 with her while she smoked. AD-A indicated R28 had poor short term memory and requested to smoke often. AD-A indicated R28 may request a cigarette right after smoking one because of her poor memory. On 6/06/2017, at 1:52 p.m. nursing assistant (NA)-A indicated any facility staff could assist R28 to smoke. NA-A stated staff would obtain the smoking materials from the nurses station, a smoking apron was retrieved from a hook which hung on the wall in the foyer. NA-A indicated staff would apply the smoking apron, light the cigarette and sit with R28 until she finished. NA-A stated the smoking apron was used so R28 would not burned. On 6/06/2017, at 2:02 p.m. NA-B indicated R28's cigarette and lighter were locked in the medication room. NA-B indicated staff would get the smoking materials from a nurse, take R28 outside, place a smoking apron on R28, light the cigarette and stay with R28 until she was finished smoking. NA-B indicated the smoking apron was used in case R28 dropped ashes on herself. NA-B verified he/she had not seen R28 drop a cigarette on herself but had witnessed her drop plenty of ashes. On 6/06/2017, at 2:35 p.m. R28 was seated in a wheel chair on the smoking patio. R28 wore a white smoking apron which covered her chest and lap. Activity aid (AA)-A sat and visited with R28 as she independently smoked the cigarette. At 2:51 p.m. AA-A removed R28's smoking apron placed it on the hook on the wall in the foyer and assisted R28 into the building. On 6/06/2017, at 2:53 p.m. AA-A indicated nursing staff would find AA-A and request he/she	2 830		

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2 830	Continued From page 16 sit with R28 while she smoked. AA-A indicated smoking materials were retrieved from the medication room, a smoking apron would be placed on R28 so that she would not burn herself and staff would then sit and visit until R28 is finished smoking. On 6/06/2017, at 3:16 p.m. R28's medical record was reviewed with nurse manager (NM)-A. NM-A confirmed the most recent smoking 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 facility practice was for each resident care be provided as directed by the assessment findings. NM-A indicated when an 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 nursing (DON) indicted the facility protocol was to perform an initial smoking assessments upon admission and then quarterly or with a change in status. The DON verified all smoking assessments were completed in the computer system. With review of R28's medical record, the DON verified R28's last smoking assessment was completed 11/3/16, and one should have been completed in February 2017. The DON indicated being unaware of a change in R28's cognition or physical condition, however; assumed if the care plan was changed to discontinue the use of the smoking apron, an assessment should have been completed. The DON further indicated R28 had previously used a smoking apron, though felt R28 no longer required one.	2 830		

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2 830	Continued From page 17 On 6/06/2017, 4:07 p.m. NM-B indicated being responsible for discontinuing the use of the smoking apron from R28's care plan. NM-B verified the most current smoking assessment was dated 11/3/16, and it indicated a smoking apron was to be utilized in order to ensure safety with smoking for R28. NM-B indicated the usual practice was to complete an assessment, document the findings in the residents progress notes and then to change the care plan if needed. NM-B verified neither an assessment nor a progress note regarding R28's smoking ability was found with review of R28's computerized chart past 11/3/16. Compression Stockings Review of R66's current physician orders dated 5/16/17, revealed an order started 3/12/17, for knee high gradient pressure stockings to be placed on in the morning and off in the evening. R66's admission Minimum Data Set (MDS) dated 3/19/17 identified R66 had diagnoses which included arthritis, pain, weakness and localized edema. The MDS further identified R66 was cognitively intact and was independent with all activities of daily living (ADL's) except toileting. Review of R66's Care Area Assessment (CAA) dated 3/20/17, identified R66 had weakness, limited range of motion, poor coordination and balance, arthritis pain and cognitive impairment with changing cognitive status. The CAA further indicated R66 required physical assistance with dressing and failed to identify R66 had edema or required compression socks. R66's care plan dated 6/6/17, identified R66 had	2 830		

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2 830	Continued From page 18 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). Review of the nursing assistant (NA) daily care sheet dated 6/8/17, identified R66 was to use knee high/thigh high compression stockings, on every morning and off at bedtime. Review of R66's medication administration record and treatment administration record from 3/1/17 to 6/8/2017 lacked monitoring for use of R66's compression stockings or swelling. On 6/05/17, at 4:33 p.m. R66 was seated in his room in his wheelchair, both feet rested on the floor. R66's ankles up to his calves were swollen and had significant indentations around the circumference of both calves from where the elastic band on the top of his regular white socks ended. R66 was not wearing compression stockings on either leg. He stated he required assistance to apply the compression stockings and staff were supposed to put on his compression socks in the morning and take them off at night before he went to bed. R66 stated the compression socks were ordered to reduce swelling and pain in his legs. He stated he felt some staff were absent minded and forgot to put them on and take them off. He stated in the past he had laid out his compression socks on the floor in his doorway to get staff's attention so they would get the hint to put them on. He stated the compression socks kept the swelling down in his legs.	2 830		

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2 830	Continued From page 19 On 6/06/17, at 2:35 p.m. R66 was in his room seated in his wheelchair with regular black socks on both feet and was not wearing compression socks to either leg. R66 had deep indentations around his mid calves where the elastic from the top of his socks were. R66 stated he should not wear these socks because they were too tight, and his legs swelled up quickly without the compression socks on. He stated staff were supposed to put the compression socks on every day and indicated staff did not consistently apply or remove his compression socks. R66 stated he had not worn his compression socks for 2 days because staff had not offered to assist with applying the compression stockings. He stated when staff do put his compression socks they sometimes forgot to take them off and then in the morning his legs were uncomfortable. He stated he felt there is a few staff he could can rely on and a lot he could not rely on. He stated he did not want to complain because he felt that made enemies and he did not want to use his call light because it aggravated the staff. On 6/06/17, at 3:03 p.m. NA-F confirmed R66 required extensive assistance to apply and remove his compression socks. She stated the NA's were responsible to put them on and take them off every day. On 6/06/17, at 3:14 p.m. NA-E stated R66 required assistance to apply his compression socks. She stated the staff usually tried to put them on every day, and stated some days R66 refused. She stated when R66 refused they would usually let the nurse know and she could usually convince him to put them on. She stated she thought R66 always had edema in his legs. On 6/06/17, at 3:22 p.m. NA-K stated he felt R66	2 830		

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2 830	Continued From page 20 needed help with his compression socks. He stated either the nurse or the NA's applied R66's compression socks and R66 was supposed to wear them every day. He stated R66 did not refuse to wear the compression socks and was willing to let him put the compression stockings on. He stated R66's legs were huge without the compression socks and R66 had told him the compression socks helped a lot with his swelling. On 6/6/17, at 3:32 p.m. registered nurse (RN)-A stated R66 required staff's assistance with applying and removing his compression socks. RN-A indicated R66 occasionally refused to wear the compression socks, however; he did not have a pattern of refusing and they had not notified his physician of any refusals. She confirmed R66's current order for the compression socks and stated she expected the NA's to put them on every morning and take them off every night. She stated R66 had a lot of edema,which varied from day to day. On 6/6/17, at 3:35 p.m. RN-A and surveyor entered R66's room. R66 was seated in his recliner with his feet elevated on the foot rests and wore regular black socks on both feet. R66 had both socks pushed down around his ankles and was not wearing his compression socks to either leg. RN-A confirmed R66 did not have his compression socks on either leg, and stated staff should have put them on this morning. RN asked R66, "Why aren't you wearing your compression socks?" R66 replied the staff forgot and I did not want to complain because it aggravated people. On 6/07/17, at 7:16 a.m. NA-G stated R66 required assistance with applying his compression socks. She stated R66 was thankful and cooperative when staff helped put his	2 830		

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	00444	A. BUILDING: _____ B. WING _____	06/08/2017

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2 830	Continued From page 21 compression socks on. She stated the NA's were responsible to apply R66 compression socks and document when they put them on and took them off. She stated R66 got up on his own in the morning and should have assistance with applying his compression socks before breakfast. She stated R66's swelling in his legs was better as long as he wore his compression socks, and stated she felt they helped to reduce R66's swelling. On 6/08/17, at 10:28 a.m. nurse manager (NM-A) confirmed R66 had a current physician's order for compression socks for chronic swelling in his legs from arthritis. She stated she expected staff to apply R66's compression stockings every morning and take them off at bedtime as directed by the care plan. She stated R66 required help with the application and removal of his compression socks. She confirmed the documentation of R66's compression socks and stated she questioned the accuracy of the documentation, as she thought he refused to wear them more than the documentation revealed. On 6/08/2017, at 1:04 p.m. during follow-up interview NM-A stated the NA's were responsible for applying R66's compression socks and documented refusals in the computer. She stated if the documentation identified several refusals for multiple days she would address it with the physician. She stated she had not personally updated the physician with any refusals, and stated there was not documentation of risk and benefit education for R66 when he refused to wear the compression socks. She stated the compression socks were a necessary treatment for R66's pain and swelling in his legs.	2 830		

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2 830	Continued From page 22 Review of R66's on and off schedule for JOBST socks from 3/12/17 to 6/8/17 revealed: 3/12/17-3/31/17, R66 had his compression socks applied every morning and removed every night with the exception of 5 days. 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	2 830		

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2 830	Continued From page 23 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.	2 830		

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2 850	Continued From page 24	2 850		
2 850	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide grooming services related to the removal of facial hair for 1 of 1 residents (R51) observed to have significant facial hair. Findings include: Review of R51's annual Minimum Data Set (MDS) dated 4/19/17, identified R51 had diagnoses which included dementia, arthritis and pain. The MDS further identified R51 had severe cognitive impairment and required extensive assistance with all activities of daily living (ADLs) except for eating. R51's Care Area Assessment (CAA) dated 4/21/17, identified R51 had dementia, arthritis and restricted mobility. The CAA further identified staff were to anticipate R51's needs and provide extensive assistance with R51's ADLs. Review of R51's care plan dated 10/29/14, identified R51 required extensive assistant of 1 staff for grooming and R51 was to be neat and clean.	2 850	Resident R51's daughter was called and electric shaver was brought to facility by family for resident's use. The resident was shaved by staff on June 10, 2017. All residents were asked if they wanted to be shaved. Any residents that did not want to be shaved had this information added to their care plan/Kardex. Those who wanted to be shaved were audited to see if they had their own shaver, if not family was contacted to bring in a shaver for them. The Shaving Policy was reviewed and updated on June 21, 2017. Social Services will ask upon admission if resident wants to be shaved. If resident does not want to be shaved, the information will be added to their care plan. If the resident does want to be shaved, an electric razor will be brought in by resident or family. Nursing staff will be educated at nurses meeting July 12, 2017 and all other staff	7/17/17

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2 850	Continued From page 25 On 6/05/17, at 5:22 p.m. R51 was observed in the dining room, seated in her wheelchair. R51 was noted to have significant facial hair. R51 had gray and light brown fuzzy hair which went from under her nose and down the sides of her mouth. R51 had a few longer, coarse hairs near corners of mouth, several shorter gray hairs under chin, a few long gray chin hairs under her chin and significant short, coarse, light brown and gray hairs under bottom lip in the crease of her chin. On 6/06/17, at 2:11 p.m. R51 was observed self-propelling down the hallway in her wheelchair and continued to have significant facial hair. On 6/07/17, at 12:39 p.m. R51 was observed in the dining room seated in a regular chair and continued to have significant facial hair. On 6/07/17, at 12:00 p.m. nursing assistant (NA)-G stated R51 was very confused and required extensive assist with ADLs. NA-G stated the usual facility practice was female residents were shaved as needed which was about every 3 weeks. She stated residents had their own razors in their bedroom drawer. She stated it was R51's bath day today and R51 should have been shaved today if she needed it. On 6/07/17, at 12:14 p.m. licensed practical nurse (LPN)-A stated R51 got confused at times and required extensive assistance with ADLs. She stated the usual facility practice was female residents were shaved every week with their bath. She stated R51 should have been shaved today with her bath. On 6/07/17, at 1:50 p.m. NA-C stated R51 was confused and required extensive assistance with	2 850	will be educated by July 17, 2017. The medical director will be updated on final policy changes on July 11, 2017. The Director of Nursing will complete random audits of all residents for shaving choices to ensure policy is being followed. Results will be discussed at QA committee meetings quarterly to ensure compliance.	

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2 850	Continued From page 26 ADLs. NA-C stated she assisted R51 with her morning cares that morning and stated she was unaware R51 had facial hair. She stated R51 should be shaved every day if she needed facial hair removal. NA-C confirmed R51's facial hair and that R51 did not have a personal razor in her room. NA-C stated R51 needed to be shaved, and she should have been shaved with her bath today. On 6/07/17, at 2:03 p.m. NA-D stated she provided R51 a bath today, and stated she doesn't keep personal razors in the tub room for sanitary reasons. She stated the NA who cared for R51 should have used R51's personal razor and shaved her this morning. On 6/08/17, at 11:08 a.m. nurse manager (NM-A) confirmed R51 had never had her own razor, and stated she wasn't sure when R51 was shaved last. She stated she expected staff to remove facial hair anytime they notice it and expected all residents looked nice. A policy related to grooming and activities of daily living (ADLs) was requested. DON stated they did not have a specific policy related to these. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could implement policies and procedures related to ensuring staff provide the necessary grooming services for residents 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)	2 850		

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2 850	Continued From page 27 days.	2 850		