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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UVMF

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 **06/02/2014** (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 **55** (L18)

13.Total Certified Beds **55** (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
	55			
(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 :
Denise Erickson, HFE NEII — 06/09/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 08/07/2014 (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
Posted 08/13/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/29/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5588

June 9, 2014

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

Dear Mr. Kelly:

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

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

Effective May 23, 2014 the above facility is certified for:

55 Skilled Nursing Facility Beds/Nursing Facilit Beds

Your facility's Medicare approved area consists of all 55 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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 9, 2014

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

RE: Project Number S5588025

Dear Mr. Kelly:

On May 1, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 17, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On June 2, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 17, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 23, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 17, 2014, effective May 23, 2014 and therefore remedies outlined in our letter to you dated May 1, 2014, will not be imposed.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245588	A. Building B. Wing	6/2/2014

Name of Facility	Street Address, City, State, Zip Code
ST WILLIAMS LIVING CENTER	212 WEST SOO STREET, BOX 30 PARKERS PRAIRIE, MN 56361

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	**05/23/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	**05/09/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	**05/09/2014**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/GA	06/09/2014	28034	06/02/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/17/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UVMF

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 **04/17/2014** (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 **55** (L18)

13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE NEII 05/12/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/27/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 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
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5588

On April 17, 2014 a standard survey was completed at this facility. Deficiencies were found, whereby corrections are required. The facility has been given an opportunity to correct before remedies would be imposed. Post Certification Revisit (PCR) to follow. Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8255

May 1, 2014

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

RE: Project Number S5588025 & F5588022

Dear Mr. Kelly:

On April 17, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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
Minnesota Department of Health
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537

Telephone: (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 May 27, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 July 17, 2014 (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 October 17, 2014 (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
Division of Compliance Monitoring

P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
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 _____	04/17/2014

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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure corrosion was removed from resident toilet room faucets, walls, a toilet tank cover and a door frame were kept in good repair to maintain a homelike environment for 8 of 8 residents (R19, R45, R8, R21, R51, R67, R16, R26). Findings include: On 4/16/14, at 1:00 p.m. during environmental tour with facility maintenance (FM)-A and FM-B, in R19 and R45's bathroom, the hot and cold faucets had green and white corrosion around the bases of the faucets. FM-A turned on the water for each faucet and there was leakage around the	F 253	The toilet that was identified to have a crack in it by the survey team was replaced by May 2, 2014. The maintenance department inspected all of the resident toilets and replaced or fixed any toilets in need of repair by May 2, 2014. The maintenance department has a new supply of toilets and toilet covers for future toilet repair or replacements. All resident sinks that had buildup or corrosion that were identified by the survey team were cleaned and repaired by the housekeeping and maintenance department. All other bathrooms were inspected on May 2, 2014 and cleaned by	5/23/14

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

Electronically Signed | 05/08/2014

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 _____	04/17/2014

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 253	Continued From page 1 bases of the faucets. - At 1:15 p.m. FM-A stated he was not aware of the leak around the faucets in R19 and R45's bathroom. FM-A indicated the water in the facility could create the corrosion and there were extra "collars" for the faucets and would be replaced. FM-A stated the maintenance staff performed weekly rounds of the resident rooms to check for any maintenance issues. FM-A confirmed the facility staff would communicate with the maintenance department through a book at the nurses' desk, or by phone call if there was an urgent issue. The maintenance book was checked daily by the maintenance staff. FM-A indicated the maintenance issues identified during the tour were not identified during weekly rounds or in the maintenance book. On 4/17/14, at 1:30 p.m., during environmental tour with facility maintenance staff (FM)-B and the facility administrator, there was a line of dime-sized depressions in R8 and R21's wall behind the door to the room at 6 inches above the floor. In R8 and R21's bathroom doorway, there were jagged areas of missing paint on both corners of the doorframe that exposed the raw metal frame. The jagged areas extended from the floor to 6 inches from the floor making the area uncleanable. In the bathroom utilized by R51 and R67, there were jagged areas of missing paint on the corners of the doorframe that extended from the floor up approximately 12 inches. FM-B stated he was not aware of the missing paint in the bathroom doorways. On 4/17/14, at 1:58 p.m. in R16 and R26's bathroom, the white porcelain toilet tank cover had a jagged crack diagonally across the left third of the porcelain. The pieces were not loose,	F 253	the housekeeping department. Any faucets that had corrosion that could not be cleaned were identified and replaced by the maintenance department. All faucets in resident bathrooms were clean and clear of corrosion and buildup by May 9, 2014. On May 2, 2014, parts were ordered to replace leaking faucets in resident rooms. All leaking faucets will be repaired by the maintenance department by May 16, 2014. A plan was immediately put in place to correct the concerns in the resident rooms that were identified by the survey to be in need of paint. The door frames identified were immediately painted. The walls that had depressions and needed paint were filled in with spackling, primed, and then repainted. The maintenance department inspected all of the other resident rooms to identify painting concerns that need to be addressed. The maintenance and housekeeping departments will have all painting and spackling of resident rooms completed by May 23, 2014. On May 2, 2014 the administrator, maintenance department, and housekeeping supervisor inspected every resident room to identify any maintenance concerns. All maintenance concerns were documented and the maintenance and housekeeping departments immediately put in place a plan to correct all concerns. On May 6, 2014 a new policy and procedure was developed to address	

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	245588	A. BUILDING _____ B. WING _____	04/17/2014

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F 253	Continued From page 2 however there were jagged chunks of porcelain missing the length of the crack. The areas of missing porcelain were light brown in color. FM-B indicated the cover had been glued and confirmed the area was uncleanable and needed to be replaced. A policy related to the maintenance of resident rooms was requested, but was not provided by the facility.	F 253	maintaining a homelike environment in resident rooms. A checklist was developed with the new policy to be completed by housekeepers during daily environmental rounds. All maintenance and housekeeping staff were educated on the new policy and procedure by May 9, 2014. The checklist that was developed will be used six days a week for every resident room by the housekeepers for a period of two months beginning on May 9, 2014. The housekeeping supervisor will audit the checklists weekly to ensure that the checklists are being completed accurately and appropriately. QA committee will monitor for staff compliance quarterly. The Housekeeping Supervisor, Administrator, and QA Committee are responsible for implementing this POC.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.	F 356		5/9/14

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F 356	Continued From page 3 The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based observation, interview and document review, the facility failed to post the actual hours of licensed and unlicensed nursing staff. This had the potential to affect 46 out of 46 residents who resided in the facility, along with families and visitors. Findings include: On 4/14/14, at approximately 1:30 p.m. the nursing hours posting was observed by the entrance of the facility. The posting was noted to lack specific hours of licensed and unlicensed nursing staff as well as number of licensed and unlicensed nursing staff for each shift time worked. - On 4/17/14, at 9:07 a.m. the nursing hours posting was again observed to lack the required specific hours and number of nursing staff.	F 356	Information was obtained from multiple sources to design a new Report of Nursing Staff. The new report contains the following items: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The policy for Report of Nursing	

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F 356	Continued From page 4 Review of the nursing hours postings from 3/11/14, through 4/17/14, revealed the actual hours and number of nursing staff were routinely excluded from the posting. On 4/17/14, at 11:20 a.m. the director of nursing (DON) verified the nursing hours posting did not include specific hours the staff worked and the number of nursing staff on each shift. DON reported she was not aware the specific hours worked and the number of staff were required on the posting. The facility's Report of Nursing Staff/Posting Notice dated 12/11/09, instructed the total number of scheduled and actual full-time equivalents (FTEs) of licensed and unlicensed nursing staff were to be included on the posting. The policy lacked instruction to reflect the actual number of nursing staff that were working and the specific (actual) hours the staff worked.	F 356	Staff/Posting Notice was updated to include the above items on 5/6/14. Education will be provided to all nursing staff by 5/9/14. The DON will audit the Report of Nursing forms 3 days per week and prior to being placed in storage binder. She will initial the bottom of the form to indicate that the form had been audited. The DON and QA Committee are responsible for implementing this POC. QA committee will monitor for staff compliance quarterly.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371		5/9/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 5 Based on observation, interview and document review, the facility failed to serve food during the evening meal service using proper food handling techniques for 6 of 6 residents (R3,R4,R12,R31,R38, R67) who were served croissant sandwiches for the evening meal. Findings include: During continued observation of the evening meal service from 5:31 p.m. to 5:52 p.m. on 4/14/14, dietary staff (DS)- A was observed serving individual resident meals at the steam table in the facility. At 5:31 p.m., DS-A assembled the food service trays with the resident meal choices. DS-A remained behind the steam table in the kitchen area,with plastic gloves on both hands. DS-A was observed wearing the same gloves through out the entire meal service as he dished up servings of foods, and touched multiple surfaces in the kitchen which included the refrigerator handle and direct contact of ready to eat foods. - At 5:33 p.m. DS-A was observed to open the refrigerator door with the gloved right hand, removed the cellophane wrap from the sandwiches, picked up the ready to eat croissant sandwich with the same right gloved hand, placed the sandwich on a plate, closed the refrigerator and continued with the meal service. This procedure was observed to be repeated again at 5:38 p.m., at 5:49 p.m., at 5:50 p.m., at 5:51 p.m., and at 5:52 p.m. for a total of six resident meals. On 4/14/15, at 5:58 p.m. the dietary manager (DM) confirmed the current facility policy and indicated she was not sure if the surface of the refrigerator was a clean surface.	F 371	Staff that was involved in the error was educated immediately on proper food handling, use of gloves, and hand washing. Arrangements were made for Claudia Rolph CDM, Safe Serve Instructor, to conduct an in-service on focusing on proper food handling techniques to include cross contamination, proper hand washing techniques, food handling, and glove use. The objective of the in-service was to understand the importance of following proper hand washing techniques in order to prevent the spread of foodborne pathogens that are a major cause of foodborne illnesses. The training took place on May 6th for all dietary employees. Over the course of a year all dietary employees are required to complete online courses through Health Care Academy; the required courses include Food Preparation and Safe Food Handling, Breaking the Chain of Infection, and Hand Hygiene. In addition to the other courses, the dietary manager also completes an annual three hour course called Dining Standards of Practice. The policy and procedure for use of plastic gloves was reviewed and updated by May 6, 2014. The policy was reviewed with staff at training. The dietary manager will complete a proper food handling audit. This audit will be completed weekly for each meal for a period of two months. Then the audit will be completed monthly thereafter.	

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F 371	Continued From page 6 On 4/14/15, at 6:05 p.m. DS-A confirmed he had handled six ready to eat sandwiches with gloves which had been worn through out the entire meal service and had previously contacted multiple surfaces in the kitchen area, including the refrigerator handle. DS-A confirmed his usual practice had been to change gloves only if visibly soiled. DS-A stated gloves would be changed if they had "gravy or butter" on them. On 4/17/14 2:22 p.m. the director of nursing (DON) confirmed the practice to touch the refrigerator handle and then directly touch food with the same gloves would not be acceptable and further stated the refrigerator handle "is not a clean surface." The facility's Use of Plastic Gloves, Policy and Procedure dated 2005 indicated staff were to prevent bacteria transfer when working with resident foods and noted #4 " Anytime a contaminated surface is touched, the gloves must be changed."	F 371	The dietary manager and QA committee are responsible for implementing this POC. QA committee will monitor for staff compliance quarterly.	

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	245588	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/16/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St Williams Living Center Building 01 was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The facility was inspected as two separate buildings: St. Williams Living Center is a 1-story building with no basement. The building was constructed at 6 different times. The original building was constructed in 1963 and was determined to be type II(000) construction. In 1967 an addition was added to the south that was determined to be of Type II(111) construction. In 1976 an addition was added to the west that was determined to be of Type II(111) construction. In 1996 additions were added to the northwest that was determined to be of Type V(111) construction. In 2001 an addition was added to the northeast that was determined to be of Type V(111) construction. In 2007 an addition was added to the southeast that was determined to be of Type II(111) Construction. The building is fully fire sprinklered throughout. The facility has a fire alarm system that includes smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 46	K 000		

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

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.

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

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K 000	Continued From page 1 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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	245588	A. BUILDING **02 - NEW BLDG** B. WING _____	**04/16/2014**

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K 000	Continued From page 1 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		