DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 30, 2022

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

RE: CCN: 245588
Cycle Start Date: June 1, 2022

Dear Administrator:

On June 28, 2022, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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 _____	C 06/01/2022

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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F 000	INITIAL COMMENTS On 5/31/22, to 6/1/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H55881882C (MN00083718), with deficiencies cited at F609, F610. The following complaint was found to be UNSUBSTANTIATED, however related deficiencies were cited. H55881883C (MN00083715), with deficiencies cited at F609, F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations	F 609		6/24/22

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

Electronically Signed | 06/17/2022

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

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F 609	Continued From page 1 involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the State Agency (SA) and the facility administrator an allegation of abuse, no later than two (2) hours after knowledge of the allegation of abuse for 2 of 2 residents (R1 and R2) reviewed for timely reporting of abuse. Findings include: R2 R2's admission Minimum Data Set (MDS) dated 5/19/22, identified R2 had diagnosis which	F 609	How corrective action will be accomplished for those residents found to have been affected by the deficient practice and other residents having the potential to be affected by the same deficient practice. -THE EMPLOYEE INVOLVED IN THE INCIDENT WAS SUSPENDED IMMEDIATELY AFTER THE ADMINISTRATOR WAS NOTIFIED OF THE ALLEGATIONS OF ABUSE. THE EMPLOYEE THAT WAS INVOLVED IN THE ALLEGATIONS OF ABUSE WAS TERMINATED FROM EMPLOYMENT	

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F 609	Continued From page 2 included anxiety disorder, major depressive disorder, and chronic obstructive pulmonary disease (COPD). The MDS indicated R2 was cognitively intact and required extensive assistance with activities of daily living (ADL's) which included, bed mobility, transfers, and toileting. R2's care plan dated 5/19/22, revealed R2 had impaired cognition and had behaviors of hollering out for help instead of using call light and directed staff to acknowledge concerns, approach non-judging, listen to concerns and offer reassurance, and update MD/family of changes in behavior. The facility SA report dated 5/21/22, at 1:40 p.m. identified R2 hollered out and (NA)-A entered R2's room to see what R2 wanted. NA-A was overheard telling R2 to "shut up" and closed R2's room door. The report indicated R2 was interviewed and was unable to recall any incidents. During an interview on 5/31/22, at 2:43 p.m. NA-B indicated on 5/20/22, at 9:45 p.m. NA-B and NA-A were seated at the desk outside of R2's room when they heard R2 yelling out. NA-B stated NA-A entered R2's room, told R2 to "shut up" and closed the door to R2's room. NA-B indicated she reported the incident to licensed practical nurse (LPN)-A at 10:00 p.m. that same evening. LPN-A stated he would notify the DON and the administrator. During an interview on 5/31/22, at 3:29 p.m. LPN-A stated on 5/20/22, after 9:00 p.m. NA-B notified him of an allegation of abuse. LPN-A indicated he emailed the DON about the	F 609	AFTER THE INVESTIGATION. -ALL STAFF WORKING WITH THE ALLEGED PERPERTRATOR AND STAFF THAT PROVIDED CARE TO R1 AND R2 DURING THE TIME OF THE INCIDENT WERE INTERVIEWED DURING THE INVESTIGATION. -THE DIRECTOR OF NURSING AND/OR RN MANAGER COMPLETED CHART REVIEWS OF RESIDENTS R1, R2, AND ALL RESIDENTS THAT RECEIVED CARE FROM THE EMPLOYEE INVOLVED IN THE INCIDENT AFTER THE INCIDENT TO DETERMINE IF ANY ADDITIONAL ABUSE OCCURRED. THE CHART REVIEW FOUND THAT THERE WAS NO NEW EVIDENCE THAT ANY ADDITIONAL ABUSE OCCURRED. -THE DIRECTOR OF NURSING AND/OR RN MANAGER INTERVIEWED RESIDENTS R1, R2, AND ALL RESIDENTS THAT RECEIVED CARE FROM THE EMPLOYEE INVOLVED IN THE INCIDENT AFTER THE INCIDENT TO DETERMINE IF ANY ADDITIONAL ABUSE OCCURRED. THE INTERVIEWS FOUND THERE WERE NO ADDITIONAL COMPLAINTS OF ABUSE. A NEW FORM TITLED VULNERABLE ADULT SUSTPECTED MALTREATMENT REPORT WAS DEVELOPED AND IMPLEMENTED. THE NEW FORM HAS A CHECKLIST THAT OUTLINES ALL OF THE ITEMS THAT NEED TO BE ADDRESSED FOR THE INITIAL REPORTING AND TIMEFRAMES FOR SUBMITTING A VA REPORT. THE NEW FORM ALSO INCLUDES A CHECKLIST	

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F 609	Continued From page 3 allegation of abuse and confirmed he had not contacted the DON directly regarding the incident. LPN-A stated the expectation was for staff to report any allegation of abuse within two hours to the DON. During a telephone interview on 5/31/22, at 3:40 p.m. NA-A indicated on 5/20/22, at 9:45 p.m. she and NA-B had a conversation while seated at the desk outside of R2's room. NA-A indicated R2 began repeating the conversation very loudly and NA-A entered R2's room and told her to be quiet. NA-A indicated she may have told R2 to be quiet however she did not tell R2 to shut up. During an interview on 6/1/22, at 8:58 a.m. administrator confirmed he was made aware of the allegation of abuse on 5/21/22, and the incident occurred on the evening of 5/20/22. Administrator stated he believed the supervisors were notified of the allegation and an email had been sent out on the evening of 5/20/22. Administrator confirmed the facility's policy was to notify the administrator immediately of any allegation of abuse however he felt it was appropriate to send an email since the incident occurred on the weekend. During an interview on 6/1/22, at 9:30 a.m. registered nurse RN-A verified she filed the report to the SA on 5/21/22, at 1:40 p.m. after the DON contacted her about the allegation of abuse. RN-A confirmed the report was filed late. During a telephone interview on 6/1/22, at 10:20 a.m. DON confirmed she had became aware of the allegation of abuse towards R2 on 5/21/22, in the morning when she reviewed her e-mails, and immediately contacted the administrator. DON	F 609	OUTLINING ALL THE STEPS THAT NEED TO BE COMPLETED FOR THE INVESTIGATION OF THE SUSPECTED MALTREATMENT. THE IMPLEMENTATION OF THIS FORM WILL ENSURE THAT ALLEGED VIOLATIONS WILL BE REPORTED IN THE APPROPRIATE TIMELINE AND THE INVESTIGATION WILL BE COMPLETED CORRECTLY. -The Reporting Suspicion of a Crime and Vulnerable Adult Act / Abuse Prevention polices were updated on 6/13/2022 to reflect the regulation of Reporting of Alleged Violations more clearly. The previous policy created confusion for staff about the 2-hour requirement of reporting abuse and serious bodily injury. -All nurses that are responsible for reporting Vulnerable Adult Allegations were trained at a nurses meeting that was held on 6/14/2022 on the following topic: All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long term care facilities) in	

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F 609	Continued From page 4 stated she contacted (RN)-A and asked her to file the report to the SA. DON indicated her expectation was for staff to notify her and the administrator immediately and the report to the SA would be filed within 2 hours of an allegation of abuse. DON confirmed she and the administrator were notified late about the allegation of abuse. R1	F 609	accordance with state law through established procedures. -On June 3, 2022 all nursing home staff were educated with information: Attention. This is to reeducate all staff that if you suspect any kind of neglect or abuse you need to notify your charge nurse, administrator, social services, DON, or you can notify yourself per our abuse policy. If you are a charge nurse and you get notified of an incident, you must act and protect the resident/residents involved and notify the administrator and/or DON Immediately if we are here or by phone if we are out of the office. You must get a hold of at least one of us verbally as soon as possible. If you are unsure then call us we are here and will discuss with you the situation. If questions please let me or your supervisor know. Thanks, Lori What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. -The previously mentioned policies were reviewed and updated. -A Vulnerable Adult Suspected Maltreatment Report form was developed to ensure all steps are completed correctly and in the appropriate timeframe for initial reporting and investigation. -Annual training for all staff will include the updated Vulnerable Adult Act / Abuse Prevention Policy. -All nurses will now complete VA reports online so that the reports will be made within the appropriate timeframe. Training will be completed with all nurses and	

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F 609	Continued From page 5 R1's quarterly Minimum Data Set (MDS) dated 4/27/22, identified R1 had moderate cognitive impairment and diagnoses which included: dementia, depression and psychotic disorder. R1's MDS indicated she required extensive assistance with bed mobility, transfers, dressing and grooming. R1's MDS identified R1 had verbal behaviors, other behaviors not directed at others and rejection of cares four to six days during the assessment period. R1's care plan revised 4/29/22, identified R1 required extensive assistance from staff with dressing, hygiene, and transfers. R1's care plan indicated R1 had episodes of hallucinations and delusions, and while hallucinating could become quite agitated with yelling and verbal aggression. The care plan listed the following interventions; acknowledge concerns, approach non-judging, listen to R1's concerns and offer reassurance. R1's care plan included a focus of vulnerability however lacked identification of a goal or interventions. R1's facility report to the State Agency (SA) submitted 5/21/22, at 9:36 a.m. indicated staff overheard nursing assistant (NA)-A tell R1 to "shut up" and to stop acting like a child when R1 was having behavioral outbursts. The report identified the incident occurred on 5/20/22, at 10:30 p.m. The report indicated staff notified the charge nurse, who e-mailed the director of nursing (DON) about the allegation. DON read the e-mail at 8:00 a.m. on 5/21/22, and notified administrator at that time. The administrator was notified 12.25 hours after the staff were aware of the allegation of abuse and the SA report was filed 13.75 hours after the staff became aware of	F 609	department managers by June 24, 2022. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. -The DON, Social Services Director, and/or Administrator will audit timeliness of the initial VA report after the report is submitted during investigative period. If any reports are found to not to be submitted in a timely manner, then education will be provided to the staff involved. The results of these audits will be monitored with the medical director and QAPI committee at Quarterly QAPI meetings. The date that each deficiency will be corrected. -This deficiency will be corrected by June 24, 2022. The administrator and DON are responsible for ensuring that the correction plan will be implemented.	

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F 609	Continued From page 6 the allegation of abuse. During an interview on 5/31/22, at 3:10 p.m. NA-B indicated on 5/20/22, around 8:15 p.m. NA-A informed her and NA-C she had told R1 to "shut up and stop acting like a child" when she had provided cares to her at around 8:00 p.m. that evening. NA-B stated she had informed licensed practical nurse (LPN)-A around 9:00 p.m. who asked them to write the details down, and LPN-A stated he would inform the director of nursing (DON) or administrator. NA-B indicated the next morning on 5/21/22, the DON called and interviewed her about the allegation. During an interview on 5/31/22, at 2:29 p.m. NA-C stated NA-A informed her and NA-B she had told R1 to "shut up and she was "acting like a little kid" on 5/20/22, around 8:00 p.m. NA-C indicated shortly after they reported the incident to LPN-A. NA-C stated no one should speak to a resident in that manner. During an interview on 5/31/22, at 3:29 p.m. LPN-A indicated NA-B and NA-C brought to his attention the allegations of abuse toward R1 by NA-A on 5/20/22, between 8 and 9 p.m. LPN-A stated he asked NA-B and NA-C to write the details of the incident down. LPN-A stated he e-mailed the details of the allegation to the DON and confirmed he had not contacted the DON immediately. During a telephone interview on 5/31/22, at 3:39 p.m. NA-A indicated R1 was yelling on the evening of 5/20/22, while she provided cares and she was not certain why. NA-A stated she had not told R1 to shut up. NA-A indicated she had informed the nursing assistant staff she had told	F 609		

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F 609	Continued From page 7 R1 to shut up however did not know why she told them that. NA-A stated she had felt stressed and vented frustrations to her teammates. NA-A indicated she was "at fault" for what she told her co-workers however stated she had provided R1 excellent care. During an interview on 6/1/22, at 8:58 p.m. the administrator confirmed he was made aware of the allegations of abuse to R1 on the morning of 5/21/22, and the incident occurred on the evening of 5/20/22. Administrator stated he believed the supervisors had been notified of the allegation and indicated an e-mail had been sent on the evening of 5/20/22. Administrator confirmed the expectation was to be notified of an abuse allegation immediately, as in their policy, however felt in this situation an e-mail was reasonable. During an interview on 6/1/22, at 9:30 a.m. registered nurse (RN)-A confirmed DON had called her on 5/21/22, and forwarded the note she had received from staff regarding the abuse allegation made towards R1. RN-A stated she had filed the SA report based on the information she had received. RN-A confirmed the report was filed late. During a telephone interview on 6/1/22, at 9:45 a.m. LPN-B confirmed she had worked the evening of 5/20/22, as charge nurse and had been informed of the allegations of abuse by LPN-A about 30 minutes before her shift ended. LPN-B stated she had read the note the nursing assistants had written for LPN-A. LPN-B indicated the note identified NA-A had told R1 to stop acting like a child. LPN-B indicated she was a new LPN and was not aware of the process for vulnerable adult reporting. LPN-B confirmed she	F 609		

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F 609	Continued From page 8 scanned the note to be provided to DON and had not reported the allegation of abuse. During a telephone interview on 6/1/22, at 10:20 a.m. DON confirmed she had became aware of the allegation of abuse towards R1 on 5/21/22, when she reviewed her e-mails. DON stated she had contacted the administrator immediately and forwarded him the e-mail. DON indicated she had contacted RN-A who was at the facility and instructed her to file a vulnerable adult report to the SA. DON confirmed the administrator and herself were notified late of the incident and the SA report was submitted late. The facility policy Vulnerable Adult Act/Abuse Prevention revised 3/3/21, identified all suspected cases or allegations of abuse would be reported to the administrator immediately. The policy indicated the administrator, along with the DON would determine action needed. The policy identified if the events that caused allegation involved abuse, the alleged violation would be reported immediately, but not later than two hours after the allegation was made. The policy identified all alleged violations would be reported immediately to the administrator AND to other officials including the SA.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F 610		6/24/22

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F 610	Continued From page 9 §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to complete a thorough investigation to assure residents were safe, and prevent further potential abuse by allowing the alleged perpetrator (AP) to continue to have access to other vulnerable adults following an allegation of abuse, for 2 of 2 residents (R1 and R2) investigated for abuse. Findings include: R2 R2's admission Minimum Data Set (MDS) dated 5/19/22, identified R2 had diagnosis which included anxiety disorder, major depressive disorder, and chronic obstructive pulmonary disease (COPD). The MDS indicated R2 was cognitively intact and required extensive assistance with activities of daily living (ADL's) which included, bed mobility, transfers, and toileting. R2's care plan dated 5/1922, revealed R2 had impaired cognition and had behaviors of hollering out for help instead of using call light and directed	F 610	How corrective action will be accomplished for those residents found to have been affected by the deficient practice and other residents having the potential to be affected by the same deficient practice. -THE EMPLOYEE INVOLVED IN THE INCIDENT WAS SUSPENDED IMMEDIATELY AFTER THE ADMINISTRATOR WAS NOTIFIED OF THE ALLEGATIONS OF ABUSE. THE EMPLOYEE THAT WAS INVOLVED IN THE ALLEGATIONS OF ABUSE WAS TERMINATED FROM EMPLOYMENT AFTER THE INVESTIGATION. -ALL STAFF WORKING WITH THE ALLEGED PERPERTRATOR AND STAFF THAT PROVIDED CARE TO R1 AND R2 DURING THE TIME OF THE INCIDENT WERE INTERVIEWED DURING THE INVESTIGATION. -THE DIRECTOR OF NURSING AND/OR RN MANAGER COMPLETED CHART REVIEWS OF RESIDENTS R1, R2, AND ALL RESIDENTS THAT RECEIVED CARE FROM THE EMPLOYEE	

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F 610	Continued From page 10 staff to acknowledge concerns, approach non-judging, listen to concerns and offer reassurance, and update MD/family of changes in behavior. Review of the facility incident report submitted to the State Agency (SA) dated 5/21/22, at 1:40 p.m. identified R2 was hollering out and (NA)-A entered R2's room to see what R2 wanted. NA-A was overheard telling R2 to shut up and closed R2's door. The report identified R2 was interviewed and was unable to recall the incident. The report indicated the director of nursing (DON) was updated via telephone and administrator was updated by DON immediately. Review of the facility investigation report to the SA submitted 5/26/22, identified NA-B overheard NA-A tell R2 to shut up and closed R2's door. The report indicated NA-A denied telling R2 to shut up however instead told her to be quiet. The report indicated NA-A was terminated on 5/24/22. R2's facility investigation report lacked documentation NA-A was suspended immediately after the allegation of abuse was reported to protect the residents. The report lacked documentation other residents were interviewed who had additionally received cares from NA-A. Further, the report lacked documentation education was provided to nursing staff to prevent further allegations of abuse from occurring in the facility. R1 R1's quarterly Minimum Data Set (MDS) dated 4/27/22, identified R1 had moderate cognitive impairment and diagnoses which included: dementia, depression and psychotic disorder. R1's MDS indicated she required extensive	F 610	INVOLVED IN THE INCIDENT AFTER THE INCIDENT TO DETERMINE IF ANY ADDITIONAL ABUSE OCCURRED. THE CHART REVIEW FOUND THAT THERE WAS NO NEW EVIDENCE THAT ANY ADDITIONAL ABUSE OCCURRED. -THE DIRECTOR OF NURSING AND/OR RN MANAGER INTERVIEWED RESIDENTS R1, R2, AND ALL RESIDENTS THAT RECEIVED CARE FROM THE EMPLOYEE INVOLVED IN THE INCIDENT AFTER THE INCIDENT TO DETERMINE IF ANY ADDITIONAL ABUSE OCCURRED. THE INTERVIEWS FOUND THERE WERE NO ADDITIONAL COMPLAINTS OF ABUSE. A NEW FORM TITLED “VULNERABLE ADULT SUSTPECTED MALTREATMENT REPORT” WAS DEVELOPED AND IMPLEMENTED. THE NEW FORM HAS A CHECKLIST THAT OUTLINES ALL OF THE ITEMS THAT NEED TO BE ADDRESSED FOR THE INITIAL REPORTING AND TIMEFRAMES FOR SUBMITTING A VA REPORT. THE NEW FORM ALSO INCLUDES A CHECKLIST OUTLINING ALL THE STEPS THAT NEED TO BE COMPLETED FOR THE INVESTIGATION OF THE SUSPECTED MALTREATMENT. THE IMPLEMENTATION OF THIS FORM WILL ENSURE THAT ALLEGED VIOLATIONS WILL BE REPORTED IN THE APPROPRIATE TIMELINE AND THE INVESTIGATION WILL BE COMPLETED CORRECTLY. -The Reporting Suspicion of a Crime and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245588	A. BUILDING _____ B. WING _____	C 06/01/2022

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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F 610	Continued From page 11 assistance with bed mobility, transfers, dressing and grooming. The MDS identified R1 had verbal behaviors, other behaviors not directed at others and rejection of cares four to six days during the assessment period. R1's care plan revised 4/29/22, identified R1 required extensive assistance from staff with dressing, hygiene, and transfers. The care plan indicated R1 had episodes of hallucinations and delusions, and while hallucinating could become quite agitated with yelling and verbal aggression. The care plan listed the following interventions: acknowledge concerns, approach non-judging, listen to R1's concerns and offer reassurance. R1's care plan included a focus of vulnerability, however lacked a goal or intervention. The facility report to the State Agency (SA) submitted 5/21/22, at 9:36 a.m. indicated staff overheard nursing assistant (NA)-A tell R1 to "shut up" and to stop acting like a child when R1 was having behavioral outbursts. The report identified the incident occurred on 5/20/22, at 10:30 p.m. The report indicated staff notified the charge nurse, who e-mailed the director of nursing (DON) about the allegation. DON read the e-mail at 8:00 a.m. on 5/21/22, and notified Administrator at that time. The report identified staff member would be placed on suspension until outcome of investigation. The report indicated the resident interviewed had been interviewed and was unable to recall any incidents. The facility investigation report to the SA submitted 5/26/22, identified NA-A had informed multiple co-workers she told R1 to shut up, and she was acting like a child. The report identified	F 610	Vulnerable Adult Act / Abuse Prevention polices were updated on 6/13/2022 to reflect the regulation of Reporting of Alleged Violations more clearly. The previous policy created confusion for staff about the 2-hour requirement of reporting abuse and serious bodily injury. The Vulnerable Adult Act / Abuse Prevention policy's investigation and reporting procedures were updated to state: Employees who have been accused of resident abuse will be immediately suspended from duty until the results of the investigation have been received by the administrator. The facility charge nurse has the authority to immediately suspend an employee until the DON and/or administrator can be reached. The investigative procedure was also updated to state: Interview all other residents to whom the accused employee provides care or services -All nurses that are responsible for reporting Vulnerable Adult Allegations were trained at a nurses meeting that was held on 6/14/2022 on the following topic: All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State	

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F 610	Continued From page 12 NA-A admitted telling co-workers the statement, however denied she actually said it to R1. The report identified NA-C was terminated on 5/24/22. The report indicated during the investigation it was discovered a second incident occurred with another resident and NA-A, and a second vulnerable adult (VA) report was filed with the SA. -R1's facility investigation report lacked documentation NA-A was suspended immediately after the allegation of abuse was reported to protect the residents. The report lacked documentation other residents were interviewed who had received cares from NA-A. Further, the report lacked documentation education was provided to nursing staff to prevent further allegations of abuse in the facility. NA-A's facility time sheet identified NA-A worked 5/20/22, from 2:15 p.m. to 10:45 p.m. During an interview on 5/31/22, at 3:10 p.m. NA-B indicated on 5/20/22, around 8:15 p.m. NA-A informed her and NA-C she had told R1 to "shut up and stop acting like a child" when she had provided cares to her at around 8:00 p.m. that evening. NA-B stated she had informed licensed practical nurse (LPN)-A around 9:00 p.m. who asked them to write the details down, and LPN-A stated he would inform the director of nursing (DON) or administrator. NA-B indicated NA-A continued to work the rest of the shift and later that evening, NA-B stated R2 began yelling out again. NA-B observed NA-A enter R2's room, told her to "shut up" and closed the door. NA-B stated she reported this additional incident to LPN-A as well. NA-B indicated the next morning on 5/21/22, the DON contacted her to inquire about the allegation.	F 610	Survey Agency and adult protective services where state law provides for jurisdiction in long term care facilities) in accordance with state law through established procedures. When staff get a complaint from a resident that a staff person who is assigned to them has said inappropriate language and resident states they are scared of having them do their cares: You should call DON/Administrator immediately as soon as the resident is safe; You would tell that resident that you will talk with the staff person and the staff person will not assist them anymore that day; If unable to get ahold of DON/Administrator you should have the staff person punch out and leave for the day and that they will need to talk with DON/Administrator prior to returning to work; A Vulnerable Adult report needs to be made to OHFC using the online site; The DON or RN manager will work with you on submitting initial report. Directions are in the VA book; Call Resident's family to notify them of the incident. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. -The previously mentioned policies were reviewed and updated. -A Vulnerable Adult Suspected Maltreatment Report form was developed to ensure all steps are completed correctly and in the appropriate timeframe for initial reporting and investigation. -Annual training for all staff will include the updated Vulnerable Adult Act / Abuse Prevention Policy.	

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F 610	Continued From page 13 During a telephone interview on 5/31/22, at 3:39 p.m. NA-A indicated R1 was yelling on the evening of 5/20/22, while she provided cares and she was not certain why. NA-A stated she had not told R1 to shut up. NA-A indicated she had informed the nursing assistant staff she had told R1 to shut up however did not know why she told them that. NA-A confirmed she had worked the rest of the shift and repeated the same statements regarding R1 to the night shift. During an interview on 6/1/22, at 8:58 a.m. administrator indicated DON completed the investigations for the allegations of abuse towards R1 and R2. Administrator confirmed DON contacted him the next morning on 5/21/22, and NA-A was suspended at that time. During a telephone interview on 6/1/22, at 9:30 a.m. registered nurse (RN)-A indicated she became aware of the allegations of abuse on the morning of 5/21/22, and was instructed by DON to file a VA report. RN-A indicated she had interviewed R1 and R2 on 5/21/22. RN-A confirmed NA-A continued to work until the end of her shift on 5/20/22. During an interview on 6/1/22, at 10:20 a.m. DON confirmed she became aware of the allegations of abuse which occurred on 5/20/22, on 5/21/22, when she reviewed her e-mail. DON indicated she had interviewed NA-A, NA-B, NA-C and LPN-A on 5/21/22. DON stated RN-A interviewed R1, R2 and another resident who NA-A had made a negative statement about. DON confirmed no other staff members or residents were interviewed during the investigation since they planned to terminate NA-A. DON indicated she	F 610	-All nurses will now complete VA reports online so that the reports will be made within the appropriate timeframe. Training will be completed with all nurses and department managers by June 24, 2022. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. -The DON, Social Services Director, and/or Administrator will audit timeliness of the initial VA report after the report is submitted during investigative period. If any reports are found to not to be submitted in a timely manner, then education will be provided to the staff involved. During the investigative period, the DON, Social Services Director, and/or Administrator will also ensure that all alleged violations are thoroughly investigated. Each VA report and investigation will be reviewed by the QAPI committee and medical director at Quarterly QAPI meetings. The date that each deficiency will be corrected. -This deficiency will be corrected by June 24, 2022. The administrator and DON are responsible for ensuring that the correction plan will be implemented.	

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F 610	Continued From page 14 had not been aware NA-A continued to work on 5/20/22, after LPN-A was notified of the allegation of abuse towards R1. DON stated she would expect the nurse to contact herself and the administrator immediately after an allegation of abuse and suspend the staff member involved. The facility policy Vulnerable Adult Act/Abuse Prevention revised 3/3/21, identified DON along with social services would thoroughly investigate complaints, determining whether they were true or false or not possible to substantiate, or disprove through interviews and examination with involved parties. The policy investigation process included; DON or designee would talk to the person reporting the incident, provide immediate intervention and corrective action if necessary, interview other residents to whom the accused employee provided care or services, and employees who had been accused for resident abuse would be reassigned to non-resident care duties or suspended from duty until the results of the investigation had been received by the administrator.	F 610		

Electronically delivered
June 9, 2022

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

RE: CCN: 245588
Cycle Start Date: June 1, 2022

Dear Administrator:

On June 1, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by September 1, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 1, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 9, 2022

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

Re: Event ID: PGC711

Dear Administrator:

The above facility survey was completed on June 1, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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 _____	C 06/01/2022

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/31/22, to 6/1/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 UNSUBSTANTIATED: H55881883C (MN00083715). The following complaint was found to be SUBSTANTIATED: H55881882C (MN00083718), however NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		