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	12/15/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure the physician and representative were notified of increased right hip pain and bruising for 1 of 1 resident (R1) reviewed for injury of unknown origin. Findings include: R1's annual Minimum Data Set (MDS) dated [DATE], identified R1 entered facility on 10/31/24, from a skilled nursing facility (SNF). He had minimal difficulty with hearing and impaired vision (sees large print, not regular print in newspaper/books). He was severely cognitively impaired without behaviors. He was dependent for toileting hygiene, required substantial/maximal assistance for all transfers, frequently incontinent of bladder, and occasionally incontinent of bowel. Diagnoses included atrial fibrillation (a common heart arrhythmia where the upper chambers (atria) quiver instead of contracting effectively, leading to an irregular and significantly increasing stroke risk) arthritis, Non-Alzhemier's dementia (a group of neurodegenerative disorders, like vascular dementia that affects cognition, behavior, and function often involving blood flow issues (vascular) or protein deposits (Lewy bodies), anxiety, depression, history of falling), anxiety, and depression. Currently taking an anticoagulant (blood thinner, reduces blood clotting, may bruise easily and take longer for bleeding to stop). R1's orders from 11/15/25 to 11/20/25, identified: -7/21/25, Acetaminophen (Tylenol) oral tablet. Give 1000 milligrams (mg) by mouth (po) every 6 hours as needed for moderate to severe pain. Do not exceed 3000 mg in 24 hours. Hold dates: 11/17/25 to 11/24/25. -7/21/25, Acetaminophen oral tablet. Give 500 mg by mouth every 6 hours as needed for mild pain. Do not exceed 3000 mg in 24 hours. Hold dates: 11/17/25 to 11/24/25. -11/5/25, Apixaban (a blood thinner used to prevent blood clots and stroke) tablet. Give 5mg by mouth two times a day related to paroxysmal Atrial Fibrillation. -11/15/25, bruise posterior right (R) upper leg into thigh. Right hip. Every shift until resolved. Discontinued on 12/17/25. -11/18/25, charting bruising R hip/leg: signs and symptoms (s/s) of improvement, pain, s/s of infection, interventions/treatments every day shift for 14 days. Discontinued on 12/19/25. -11/20/25, charting bruising to R hip/leg and R low back/flank s/s of improvement, pain, s/s of infection, interventions, and treatments every day shift for 14 days. Discontinued 12/4/25.R1's electronic medication administration record (EMAR) from 11/8/25 through 11/17/25, identified: Tylenol 500 mg was administered three times from 11/8/25 through 11/10/25, for right hip pain ranged from two to four on a scale of zero to 10. Tylenol 1000 mg was administered six times from 11/11/25 through 11/17/25, for right hip pain ranged from three to eight on a scale of zero to10. R1's care plan dated 12/17/25, identified: all transfers (started 10/9/25) sit to stand with assist of two and as needed (PRN) Hoyer lift (full body mechanical lift) for pain or difficulty standing/following directions, resolved on 12/17/25. Transfer (started on 12/17/25) Hoyer lift with two assist using the hourglass large sling for all transfers. Potential for falls related to weakness, history of falls, cognitive impairment with impaired safety awareness, visual deficit/blind in right eye, use of psychotropic medications, and impaired balance. Staff were directed to approach from front or left side, floor mat, hi/low bed, toileting schedule, provide a safe environment, gripper socks, anti-reverse brakes on wheelchair, and call don't fall sign place in room and bathroom. He had knee pain due to arthritis, right artificial knee joint and restless leg syndrome (RLS). Impaired cognition related to short term memory problem, time orientation difficulty, and difficulty hearing. Staff were directed to report changes in cognitive status. R1 was a vulnerable adult related to assistance needed for activities of daily living (ADLS), impaired communication and decision-making skills, and impaired mobility. Staff were directed to listed to his concerns and report any inappropriate or suspicious behaviors to the proper authorities. R1's progress notes from 11/10/24, through 11/17/25, identified: -On 11/10/25 at 4:24 a.m., noted during cares an approximate four centimeter (cm) scabbed scratch area noted on right hip located where the edge of the brief touches his skin. -On 11/10/25 at 7:41 p.m., gave 500 mg Tylenol po every six hours PRN for mild pain. R1 grimacing and with rolling and repositioning. Follow-up at 8:49 p.m., effective pain zero out of 10. -11/10/25 at 11:17 p.m., Weekly skin inspection has multiple scabbed areas on right lower extremity and face. No bruising. -11/11/25 at 5:38 p.m., Gave 1000 mg Tylenol po every six hours PRN for moderate to severe pain. R1 jumpy in wheelchair seat at evening meal. Reporting hip pain. Follow-up at 7:57 p.m., effective pain zero out of 10. -11/12/25 at 11:12 a.m., Unable to stand today. -11/13/25 at 2:46 p.m., Bruise noted to right upper groin/hip area red/purple to center and yellowing around edges. He denied cause being from any suspicious or inappropriate behavior. Bruise does not appear suspicious. Denies pain. -11/13/25 at 2:49 p.m., Gave 1000 mg Tylenol po as needed for moderate to severe pain. Complained of right hip pain and facial grimacing. Follow-up at 4:28 p.m.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to report an allegation of potential abuse within 2 hours for 1 of 1 resident (R1) with an injury of unknown origin. Findings include: R1's annual Minimum Data Set (MDS) dated [DATE], identified entered facility on 10/31/24, from a skilled nursing facility (SNF). He had minimal difficulty with hearing and impaired vision (sees large print, not regular print in newspaper/books). He was severely cognitively impaired without behaviors. He required substantial/maximal assistance for all transfers. Diagnoses included atrial fibrillation (a common heart arrhythmia where the upper chambers (atria) quiver instead of contracting effectively, leading to an irregular and significantly increasing stroke risk) arthritis, Non-Alzhemier's dementia (a group of neurodegenerative disorders, like vascular dementia that affects cognition, behavior, and function often involving blood flow issues (vascular) or protein deposits (Lewy bodies), anxiety, depression, history of falling), anxiety, and depression. Currently taking an anticoagulant (blood thinner, reduces blood clotting, may bruise easily and take longer for bleeding to stop). R1's orders dated 11/5/25, Apixaban (a blood thinner used to prevent blood clots and stroke) tablet. Give 5mg (milligrams) by mouth two times a day related to paroxysmal Atrial Fibrillation. R1's electronic medication administration record (EMAR) from 11/8/25 through 11/17/25, identified: Tylenol 500 mg was administered three times from 11/8/25 through 1/10/25, for right hip pain ranged from two to four out of 10. Tylenol 1000 mg was administered six times from 11/11/25 through 11/17/25, for right hip pain ranged from three to eight out of 10. R1's care plan dated 12/17/25, identified: all transfers (started 10/9/25) sit to stand with assist of two and as needed (PRN) Hoyer lift for pain or difficulty standing/following directions, resolved on 12/17/25. Transfer (started on 12/17/25) Hoyer lift with 2 assist using the hourglass large sling for all transfers. Potential for falls related to weakness, history of falls, cognitive impairment with impaired safety awareness, visual deficit/blind in right eye, use of psychotropic medications, and impaired balance. Staff were directed to approach from front or left side, floor mat, hi/low bed, toileting schedule, provide a safe environment, gripper socks, anti-reverse brakes on wheelchair, and call don't fall sign place in room and bathroom. He had knee pain due to arthritis, right artificial knee joint and restless leg syndrome (RLS). Impaired cognition related to short term memory problem, time orientation difficulty, and difficulty hearing. Staff were directed to report changes in cognitive status. R1 was a vulnerable adult related to assistance needed for activities of daily living (ADLS), impaired communication and decision-making skills, and impaired mobility. Staff were directed to listen to his concerns and report any inappropriate or suspicious behaviors to the proper authorities. R1's progress notes from 11/10/24, through 11/17/25, identified: -On 11/10/25 at 4:24 a.m., noted during cares an approximate 4 centimeter (cm) scabbed scratch area noted on right hip located where the edge of the brief touches his skin. -On 11/10/25 at 7:41 p.m., gave 500 mg Tylenol po every six hours PRN for mild pain. R1 grimacing and with rolling and repositioning. Follow-up at 8:49 p.m. effective pain zero out of 10. -11/10/25 at 11:17 p.m., Weekly skin inspection has multiple scabbed area on right lower extremity and face. No bruising. -11/11/25 at 5:38 p.m., Gave 1000 mg Tylenol po (by mouth) every six hours PRN for moderate to severe pain. R1 jumpy in wheelchair seat at evening meal. Reporting hip pain. Follow-up at 7:57 p.m., effective pain zero out of 10. -11/12/25 at 11:12 a.m., Unable to stand today. -11/13/25 at 2:46 p.m., Bruise noted to right upper groin/hip area red/purple to center and yellowing around edges. He denied cause being from any suspicious or inappropriate behavior. Bruise does not appear suspicious. Denies pain. -11/13/25 at 2:49 p.m., Gave 1000 mg Tylenol po as needed for moderate to severe pain. Complained of right hip pain and facial grimacing. Follow-up at 4:28 p.m. effective pain zero out of 10. -11/14/25 at 12:33 a.m., gave 1000 mg Tylenol PRN for moderate to severe pain. Right hip pain. Follow up at 3:08 a.m., effective pain zero out of 10. -11/14/25 at 1:50 p.m., Gave Tylenol. Wiggling around in chair and swearing under his breath when he moved a certain way or when he tried to hold up his feet. Pain rated eight out of 10 using PAIN-AD scale (assesses pain in residents with cognitive impairment). Follow-up at 5:23 p.m. , effective pain zero out of 10. -11/14/25 at 11:40 p.m., Gave Tylenol for moderate to severe pain. Right hip pain. Follow-up at 1:43 a.m., effective pain zero out of 10. -11/15/25 at 5:18 a.m., Bruising observed above posterior right knee and extended into upper posterior thigh. No pain with palpitation. -11/15/25 at 9:54 a.m., Gave Tylenol for moderate to severe pain. Right hip pain. Follow up at 12:00 p.m., effective pain two out of 10. -11/15/25 at 5:28 p.m., Gave Tylenol for complaints of increased right hip pain. Follow up at 7:26 p.m., ineffective. Pain six out of 10. Stated his pain was the same or worse since Tylenol administration. Facial

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and document review the facility failed to thoroughly investigate an allegation of potential resident abuse for 1 of 1 residents (R1) who was found to have an injury of unknown origin. Findings include: R1's annual Minimum Data Set (MDS) dated [DATE], identified entered facility on 10/31/24, from a skilled nursing facility (SNF). He had minimal difficulty with hearing and impaired vision (sees large print, not regular print in newspaper/books). He was severely cognitively impaired without behaviors. He was dependent for toileting hygiene, required substantial/maximal assistance for all transfers, frequently incontinent of bladder, and occasionally incontinent of bowel. Diagnoses included atrial fibrillation (a common heart arrhythmia where the upper chambers (atria) quiver instead of contracting effectively, leading to an irregular and significantly increasing stroke risk) arthritis, Non-Alzhemier's dementia (a group of neurodegenerative disorders, like vascular dementia that affects cognition, behavior, and function often involving blood flow issues (vascular) or protein deposits (Lewy bodies), anxiety, depression, history of falling), anxiety, and depression. Currently taking an anticoagulant (blood thinner, reduces blood clotting, may bruise easily and take longer for bleeding to stop). R1's orders identified on 11/5/25, Apixaban (a blood thinner used to prevent blood clots and stroke) tablet. Give 5mg (milligrams) by mouth two times a day related to paroxysmal Atrial Fibrillation. R1's electronic medication administration record (EMAR) from 11/8/25 through 11/17/25, identified: Tylenol 500 mg was administered three times from 11/8/25 through 1/10/25, for right hip pain ranged from two to four out of 10. Tylenol 1000 mg was administered six times from 11/11/25 through 11/17/25, for right hip pain ranged from three to eight out of 10. R1's care plan dated 12/17/25, identified: all transfers (started 10/9/25) sit to stand with assist of two and as needed (PRN) Hoyer lift for pain or difficulty standing/following directions, resolved on 12/17/25. Transfer (started on 12/17/25) Hoyer lift with 2 assist using the hourglass large sling for all transfers. Potential for falls related to weakness, history of falls, cognitive impairment with impaired safety awareness, visual deficit/blind in right eye, use of psychotropic medications, and impaired balance. Staff were directed to approach from front or left side, floor mat, hi/low bed, toileting schedule, provide a safe environment, gripper socks, anti-reverse brakes on wheelchair, and call don't fall sign place in room and bathroom. He had knee pain due to arthritis, right artificial knee joint and restless leg syndrome (RLS). Impaired cognition related to short term memory problem, time orientation difficulty, and difficulty hearing. Staff were directed to report changes in cognitive status. R1 was a vulnerable adult related to assistance needed for activities of daily living (ADLS), impaired communication and decision-making skills, and impaired mobility. Staff were directed to listed to his concerns and report any inappropriate or suspicious behaviors to the proper authorities. R1's progress notes from 11/10/24, through 11/17/25, identified: -On 11/10/25 at 4:24 a.m., noted during cares an approximate four centimeter (cm) scabbed scratch area noted on right hip located where the edge of the brief touches his skin. -On 11/10/25 at 7:41 p.m., gave 500 mg Tylenol po every six hours PRN for mild pain. R1 grimacing and with rolling and repositioning. Follow-up at 8:49 p.m., effective pain zero out of 10. -11/10/25 at 11:17 p. m., Weekly skin inspection has multiple scabbed areas on right lower extremity and face. No bruising. -11/11/25 at 5:38 p.m., Gave 1000 mg Tylenol po every six hours PRN for moderate to severe pain. R1 jumpy in wheelchair seat at evening meal. Reporting hip pain. Follow-up at 7:57 p.m., effective pain zero out of 10. -11/12/25 at 11:12 a.m., Unable to stand today. -11/13/25 at 2:46 p.m., Bruise noted to right upper groin/hip area red/purple to center and yellowing around edges. 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