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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0H11

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00438

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245486**
2.STATE VENDOR OR MEDICAID NO.
(L2) **847242400**

3. NAME AND ADDRESS OF FACILITY
(L3) **PERHAM LIVING**
(L4) **735 THIRD STREET SOUTHWEST**
(L5) **PERHAM, MN** (L6) **56573**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/12/2016** (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)
09/30

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

12.Total Facility Beds **96** (L18)
13.Total Certified Beds **96** (L17)

10.THE FACILITY IS CERTIFIED AS:
✓ 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
	96			
(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 :
Gail Anderson, Unit Supervisor 07/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/30/2016 (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
07/01/1987
(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
06/30/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245486

August 30, 2016

Mr. Charles Hofius, Administrator
Perham Living
735 Third Street Southwest
Perham, MN 56573

Dear Mr. Hofius:

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 June 23, 2016 the above facility is certified for

96 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 96 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 eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 21, 2016

Ms. Katie Lundmark, Administrator
Perham Living
735 Third Street Southwest
Perham, Minnesota 56573

RE: Project Number S5486025

Dear Ms. Lundmark:

On June 1, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 19, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On July 12, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 27, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 19, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 23, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 19, 2016, effective June 23, 2016 and therefore remedies outlined in our letter to you dated June 1, 2016, 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
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245486	A. Building B. Wing	7/12/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PERHAM LIVING	735 THIRD STREET SOUTHWEST PERHAM, MN 56573

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241 Reg. # 483.15(a) LSC	Correction Completed 06/23/2016	ID Prefix F0465 Reg. # 483.70(h) LSC	Correction Completed 06/23/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	GA/mm	07/21/2016	28034	28034
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
5/19/2016	[ ] 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245486 Y1	A. Building 01 - 1970 BUILDING B. Wing Y2	6/27/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PERHAM LIVING	735 THIRD STREET SOUTHWEST PERHAM, MN 56573

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0018	06/23/2016	LSC K0029	06/23/2016	LSC K0038	06/23/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0046	06/23/2016	LSC K0050	06/23/2016	LSC K0062	06/23/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TL/mm	07/21/2016	36536	06/27/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/17/2016

☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245486 Y1	A. Building 02 - 2005 BUILDING B. Wing Y2	6/27/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PERHAM LIVING	735 THIRD STREET SOUTHWEST PERHAM, MN 56573

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0018	06/23/2016	LSC K0046	06/23/2016	LSC K0050	06/23/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0062	06/23/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	TL/mm	07/21/2016	36536	06/27/2016
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
[ ]				

FOLLOWUP TO SURVEY COMPLETED ON	
5/17/2016	[ ] 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: 0H11

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00438

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245486**

2.STATE VENDOR OR MEDICAID NO.
(L2) **847242400**

3. NAME AND ADDRESS OF FACILITY
(L3) **PERHAM LIVING**
(L4) **735 THIRD STREET SOUTHWEST**
(L5) **PERHAM, MN** (L6) **56573**

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 **05/19/2016** (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)
09/30

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

12.Total Facility Beds **96** (L18)

13.Total Certified Beds **96** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	96			
(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 :
Sherri Softing, HPS SWS — 06/15/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 06/30/2016 (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
07/01/1987
(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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 1, 2016

Ms. Katie Lundmark, Administrator
Perham Living
735 Third Street Southwest
Perham, Minnesota 56573

RE: Project Number S5486025

Dear Ms. Lundmark:

On May 19, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the 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:

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

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140 Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 28, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 28, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by August 19, 2016 (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 November 19, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245486	A. BUILDING _____ B. WING _____	05/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERHAM LIVING	735 THIRD STREET SOUTHWEST PERHAM, MN 56573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide a dignified dining experience for 1 of 2 residents (R77) observed during breakfast in the Harvestglen neighborhood. Findings include: R77's quarterly Minimum Data Set (MDS) identified R77 was cognitively intact, independent with eating, and had diagnoses which included dementia and anxiety.	F 241	F241 A direct conversation with DA-A (completed 5/20/16) and dietary department took place underscoring and educating on the topic of acting and speaking in a professional and dignified manner. The second step includes an all-employee educational session on what it means to speak and act in a professional and dignified manner. This includes a presentation of our core values and facility wide expectations and an inclusive	6/23/16

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

Electronically Signed | 06/09/2016

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F 241	Continued From page 1 R77's care plan, dated 3/8/16 identified R77 was at risk for impaired activities of daily living (ADL) function due to cognitive impairment due to impaired attention skills. The careplan further identified R77 was able to feed herself after set up, preferred to sit in the dining room, and staff were to encourage R77 to socialize and interact with table mates during meals. R77's Care Area Assessment (CAA), dated 9/16/15 identified R77 had dementia, mental health problems, weakness and difficulty expressing her ideas and wants because of her confusion and slowed thought process. The CAA indicated R77 required supervision at meals so she continued the task of eating, had disorganized thought processes and couldn't complete a task she had started. The CAA also identified R77 had dementia which interfered with eating due to short attention span which included slow eating and drinking. On 5/19/16, at 11:06 a.m. R47 and R77 were seated together at a dining room table in front of the kitchenette area of the Harvestglen neighborhood. The kitchenette area was open to the dining room, with the area both audible and visible to R47 and R77. Nursing assistant(NA)-A stood at the kitchenette counter, washing dishes at the sink when dietary aide (DA)-A walked from the dining room into the entryway of the kitchenette. DA-A stood in the entry way, less than 10 feet from R77, who remained seated at the table and stated in a loud and harsh voice, "Is she still eating?, are you kidding me?" DA-A proceeded to walk into the pantry of the kitchenette and closed the door. R77 remained seated at the table of the kitchenette dining room with R47.	F 241	discussion on how staff can improve and maintain their professionalism in the workplace while also keeping close relationships with residents. This education will be brought to staff within the organization. Registered Nurse, LPN□s, Nursing Assistants, Household Coordinators, Social Services, Administrator, DON, Dietary, Laundry, Housekeeping and Environmental Services. The educational of all staff will be completed by 6/23/2016. Review of core values and policies will also occur to ensure alignment with organizational goals. Ongoing monitoring and random audits will occur to ensure resident/staff interactions are professional and dignified to remain in compliance. It will be reviewed at the Quality Assurance Committee for ongoing quality assurance of the process. The QA Committee will determine ongoing needs. Persons responsible include Director of Nutrition Services, Director of Nursing and Administrator or designee.	

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F 241	Continued From page 2 On 5/19/16, at 11:08 a.m. NA-A identified the residents in the dining room as R47 and R77, and confirmed DA-A made the loud, harsh remarks about R77. NA-A confirmed DA-A stood in the same area as R77 when DA-A made the harsh, loud comments, and stated she felt DA-A had not been respectful towards R77. NA-A indicated she felt DA-A had not treated R77 in a dignified manner when she made the comments about R77 out loud. On 5/19/16, at 11:11 a.m. DA-A stated R77 had been in the dining room for quite awhile today. DA-A stated R77 sometimes took a long time to eat and the time depended on how she was doing on that day. DA-A confirmed R47 had just came out to breakfast, and her comments identified R77. DA-A confirmed her comments were not dignified, and confirmed R77 could have heard her make the negative remarks. On 5/19/16, at 11:20 a.m. registered nurse clinical coordinator (RNCC-A) stated R77 was a "cute little putsy lady." She stated R77 took a long time to eat and sometimes R77 couldn't focus. She stated she felt staff speaking harsh, loud, negative comments about a resident was a dignity concern, and if family had been present, they could have heard the negative remarks also. She stated she expected staff to keep those type of conversations to themselves, or to share in a private area only. She stated she felt DA-A's remarks were undignified. On 5/19/16, at 4:18 p.m. R77 stated she had to fill out her own paper menu by hand routinely before dietary gave her the meal she had chosen. She stated it took her awhile to write down what she	F 241		

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F 241	Continued From page 3 wanted to eat because she was a slow thinker. She stated she liked breakfast, and it was her best meal of the day in terms of amount of food eaten by her compared to the other 2 meals. On 5/19/16, at 4:39 p.m. DON stated when employees were hired the staff received dignity training and were told of the facility expectations regarding dignity and how to treat residents at that time. She stated staff knew her expectations for resident treatment, and this was not common practice. She stated she expected staff to treat residents as they would like to be treated themselves. Upon review of the facilities core values provided by the DON, undated, identified under the core value of respect staff were to display a high regard and consideration for the dignity and uniqueness of everyone.	F 241		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide appropriate maintenance to resident rooms numbered (404, 502, 507, 608, 610, 611, 713, 716). In addition, the facility failed to ensure resident rooms numbered (307 & 709) was kept clean and free of odors reviewed for environmental concerns.	F 465	F465 Rooms identified were cleaned immediately on 5/19/16 to ensure cleanliness. Cleaning checklists were reviewed for appropriate frequency of cleaning within each household. Rooms identified as needed wall repair were	6/23/16

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F 465	Continued From page 4 Findings include: On 5/19/16, from 11:30 a.m. to 11:46 a.m. a tour of the facility was completed with the environmental service director (ESD). The ESD verified the following resident room concerns: ·In room 307, toilet had a black substance which covered the entire area near the exit hole in the toilet bowl. ·In room 404, bathroom walls gouged with missing paint near the bathroom door. ·In room 502, both corners in room had several areas by the bathroom door which were gouged and had missing paint. ·In room 507, room and bathroom walls had several areas with gouges and missing paint ·In room 608, bathroom walls gouged with missing paint near the door. ·In room 610, bathroom walls gouged with missing paint. In addition, the bathroom faucet had lime build up over the entire faucet. ·In room 611, bathroom walls gouged with missing paint. In addition, the bathroom faucet had lime build up over the entire faucet. ·In room 709, toilet had a reddish brown substance under the rim of the bowl, and the bathroom smelled of urine. ·In room 713, bathroom walls gouged near the toilet and door with missing paint. ·In room 716, bathroom walls gouged near the toilet and door with missing paint. The ESD confirmed resident rooms 307 and 709 lacked appropriate housekeeping. The ESD also confirmed the gouges identified in the rooms listed above were consistently large and obvious,	F 465	immediately added to the maintenance request log on 5/19/16. Staff educated on cleaning schedule frequency during household huddles, meetings and report. All rooms, including bathrooms will be inspected during semi-annual inspection process. Ongoing monitoring and random audits will occur to ensure resident bathrooms continue to be clean and walls are in good repair. The audits will be reviewed at the Quality Assurance Committee for ongoing quality assurance of the process. The QA Committee will determine ongoing needs. All staff education and cleaning completed by 6/23/16. Wall repair was scheduled immediately and will be completed by 7/31/16 by contractor or staff. Person Responsible: Facilities Director, Household Coordinators, Director of Nutrition Services, Director of Nursing and Administrator or Designee.	

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F 465	Continued From page 5 average gouges measured 3-4"x 8-12." On 5/19/16, at 11:14 a.m. the ESD confirmed he had not received work orders requesting repairs for the above concerns identified. The ESD reported all staff were expected to notify the maintenance department when repairs were needed through the computerized maintenance request system. The ESD stated the maintenance department had not conducted any scheduled routine environmental walk through inspections of resident rooms and bathrooms. No routine maintenance schedule for maintenance and up keep for resident rooms were provided. A facility maintenance policy was requested, but was not provided.	F 465		

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K 000	INITIAL COMMENTS FIRE SAFETY 01 1970 Building and 1979 addition THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Perham Memorial Home 01 Main Building was found not 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/09/2016

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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K 000	Continued From page 1 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility was surveyed as 2 separate buildings: Perham Memorial Home was constructed at 3 different times. The original building, a 1-story building constructed in 1970 and was determined to be of Type II(000) construction. In 1979, a 1-story with a basement was added to the south west of the original building and was determined to be of Type II(222) construction. However, the building addition is not separated by a 2-hour fire barrier. These 2 buildings were completely renovated in 2006. In 2005 a 2-story building with basement was added to the north west of the 1970 building and was determined to be of Type II(222) construction. The building is divided into 8 smoke compartments by 30- minute, 1- hour and 2- hour fire barriers.	K 000		

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K 000	Continued From page 2 The facility is completely protected by an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detectors in the corridors, spaces open to the corridors and in all resident rooms that is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. All areas requiring automatic fire detection in accordance with the Minnesota State Fire Code (MSFC) 2007 edition have been installed. The facility has a capacity of 96 beds and had a census of 91 at the time of the survey.	K 000		
K 018 SS=E	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by	K 018		6/23/16

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K 018	Continued From page 3 CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke resistance of 3 corridor doors according to NFPA 101 LSC (00) section 19.3.6.3.1. This deficient practice could affect the safety of 17 of the 91 residents and an undetermined amount of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 7:45 am to 1:30 pm on 05/17/2016 observations and staff interview revealed the following rooms did not have latching doors that open to the corridor. 1. Two resident room doors (306 & 307) in the existing building 2. The utility room door of the transition wing in the existing building. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor.	K 018	K018 Doors 306, 307 and Transitions utility room doors will be corrected to latch securely. All doors in the facility will monitored on a semi-annual basis to identify, detect, correct all other doors that may exhibit this issue. Completed by 6/23/2016. Person Responsible: Facilities Director	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the	K 029	K029	6/23/16

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K 029	Continued From page 4 facility failed to maintain smoke-resisting partitions and doors in 1 of the hazardous rooms in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect all staff and visitors using that level. Findings include: On the facility tour between 7:45 am to 1:30 pm on 05/17/2016 observations and staff interview revealed wall penetrations in the main laundry in the lower level. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor.	K 029	Sheetrock will be added to the addition of the identified area to cover the wall penetrations. Fire caulking and seal to all penetrations will occur as well in this area. A process is now implemented that requires vendors that work in the facility are required to have the work inspected and signed off prior to the ceiling tiles being replaced and the ceiling closed. This will be reviewed in the semi-annual basis to the facility inspection process. Completed by 6/23/2016. Person Responsible: Facilities Director	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain 1 exits in accordance with the egress requirements of NFPA 101 Life Safety Code (00) section 7.2.1.3, floor level. This decficient practice could affect the safe and efficient exiting of 15 of the 91residents, staff and visitors. Findings include: On the facility tour between 7:45 am to 1:30 pm on 05/17/2016 observations and staff interview revealed the exterior walking surface at the exit near the Occupational therapy room exceeded the maximum allowable height difference without a bevel or ramp.	K 038	K038 The facility has a signed contract with contractor to remove and replace the sidewalk. Complete by 07/15/2016. This sidewalk was marked with caution until replacement is complete. All facility sidewalks will be inspected during semi-annual inspection process. Person Responsible: Facilities Director	6/23/16

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K 038	Continued From page 5 This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor.	K 038		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. This STANDARD is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting has been tested in accordance with NFPA LSC (00) Section 7.9, 19.2.9.1. This deficient practice could affect all 91 residents, and an undetermined amount of staff and visitors in the event of an emergency evacuation during a power outage. Findings include: On the facility tour between 7:45 am to 1:30 pm on 05/17/2016 record review and staff interview revealed the emergency lights were not tested in the 4th quarter of 2015. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor.	K 046	K046 This issue was identified and corrected prior to the inspection. We now have this on a maintenance prevention calendar and have staff assigned to this process. Monitored monthly for review. This was corrected February 2016. Person Responsible: Facilities Director	6/23/16
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and	K 050		6/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245486	A. BUILDING **01 - 1970 BUILDING** B. WING _____	**05/17/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERHAM LIVING	**735 THIRD STREET SOUTHWEST PERHAM, MN 56573**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 6 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 91 residents and undetermined amount of staff and visitors Findings include: On the facility tour between 7:45 am to 1:30 pm on 05/17/2016 record review and staff interview revealed in the last 12 months there were no records that the following fire drills were conducted. 1. One drill in the first quarter of 2016 2. All drills in the third and fourth quarter of 2015 This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor.	K 050	K050 This issue was identified and corrected prior to the inspection. We now have this on a fire drill calendar and have staff assigned to this process. Monitored monthly for review to assure completion. This was corrected February 2016. We added the name of the person at the alarm facility for documentation of the contact at the alarm center. We also have added the alerts to the Facility Director and the Safety Director for any alarms that are received by the alarm company. Person Responsible: Facilities Director	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of	K 062	K062 This issue was identified and corrected prior to the inspection. We now have this on a maintenance prevention calendar and have staff assigned to this process. Monitored monthly for review to assure completion. This was corrected February	6/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245486	A. BUILDING **01 - 1970 BUILDING** B. WING _____	**05/17/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERHAM LIVING	**735 THIRD STREET SOUTHWEST PERHAM, MN 56573**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 7 Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 91 residents and an undtermined amount of staff and visitors. Findings include: On the facility tour between 7:45 am to 1:30 pm on 05/17/2016 record review and staff interview revealed in the last 12 months there were no records of the quarterly sprinkler tests for the third and fourth quarter of 2015. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor.	K 062	2016. Person Responsible: Facilities Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245486	A. BUILDING **02 - 2005 BUILDING** B. WING _____	**05/17/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERHAM LIVING	**735 THIRD STREET SOUTHWEST PERHAM, MN 56573**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 02 2005 Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Perham Memorial Home 01 Main Building was found not 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 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/09/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245486	A. BUILDING **02 - 2005 BUILDING** B. WING _____	**05/17/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERHAM LIVING	**735 THIRD STREET SOUTHWEST PERHAM, MN 56573**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility was surveyed as 2 separate buildings: Perham Memorial Home was constructed at 3 different times. The original building, a 1-story building constructed in 1970 and was determined to be of Type II(000) construction. In 1979, a 1-story with a basement was added to the south west of the original building and was determined to be of Type II(222) construction. However, the building addition is not separated by a 2-hour fire barrier. These 2 buildings were completely renovated in 2006. In 2005 a 2-story building with basement was added to the north west of the 1970 building and was determined to be of Type II(222) construction. The building is divided into 8 smoke compartments by 30- minute, 1- hour and 2- hour fire barriers.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245486	A. BUILDING **02 - 2005 BUILDING** B. WING _____	**05/17/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERHAM LIVING	**735 THIRD STREET SOUTHWEST PERHAM, MN 56573**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The facility is completely protected by an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detectors in the corridors, spaces open to the corridors and in all resident rooms that is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. All areas requiring automatic fire detection in accordance with the Minnesota State Fire Code (MSFC) 2007 edition have been installed. The facility has a capacity of 96 beds and had a census of 91 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke resistance of 3 corridor doors according to NFPA 101 LSC (00) section 18.3.6.3.1. This deficient practice could affect the safety of 32 of the 91 residents and an	K 018	K018 Doors 613 will be corrected to latch securely. All doors in the facility will monitored on a semi-annual basis to identify, detect, correct all other doors that	6/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245486	A. BUILDING **02 - 2005 BUILDING** B. WING _____	**05/17/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERHAM LIVING	**735 THIRD STREET SOUTHWEST PERHAM, MN 56573**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 3 undetermined amount of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 7:45 am to 1:30 pm on 05/17/2016 observations and staff interview revealed the following room did not have latching doors that open to the corridor. 1. One resident room door (613) in the 2005 addition. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor.	K 018	may exhibit this issue. Completed by 6/23/2016. Person Responsible: Facilities Director	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. This STANDARD is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting has been tested in accordance with NFPA LSC (00) Section 7.9, 18.2.9.1. This deficient practice could affect all 91 residents, and an undetermined amount of staff and visitors in the event of an emergency evacuation during a power outage. Findings include: On the facility tour between 7:45 am to 1:30 pm on 05/17/2016 record review and staff interview revealed the emergency lights were not tested in the 4th quarter of 2015. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor.	K 046	K046 This issue was identified and corrected prior to the inspection. We now have this on a maintenance prevention calendar and have staff assigned to this process. Monitored monthly for review. This was corrected February 2016. Person Responsible: Facilities Director	6/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245486	A. BUILDING **02 - 2005 BUILDING** B. WING _____	**05/17/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERHAM LIVING	**735 THIRD STREET SOUTHWEST PERHAM, MN 56573**

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K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 18.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 91 residents and undetermined amount of staff and visitors Findings include: On the facility tour between 7:45 am to 1:30 pm on 05/17/2016 record review and staff interview revealed in the last 12 months there were no records that the following fire drills were conducted. 1. One drill in the first quarter of 2016 2. All drills in the third and fourth quarter of 2015 This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor.	K 050	K050 This issue was identified and corrected prior to the inspection. We now have this on a fire drill calendar and have staff assigned to this process. Monitored monthly for review to assure completion. This was corrected February 2016. We added the name of the person at the alarm facility for documentation of the contact at the alarm center. We also have added the alerts to the Facility Director and the Safety Director for any alarms that are received by the alarm company. Person Responsible: Facilities Director	6/23/16
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are	K 062		6/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245486	A. BUILDING **02 - 2005 BUILDING** B. WING _____	**05/17/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERHAM LIVING	**735 THIRD STREET SOUTHWEST PERHAM, MN 56573**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 5 inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 18.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 91 residents and an undtermined amount of staff and visitors. Findings include: On the facility tour between 7:45 am to 1:30 pm on 05/17/2016 record review and staff interview revealed in the last 12 months there were no records of the quarterly sprinkler tests for the third and fourth quarter of 2015. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor.	K 062	K062 This issue was identified and corrected prior to the inspection. We now have this on a maintenance prevention calendar and have staff assigned to this process. Monitored monthly for review to assure completion. This was corrected February 2016. Person Responsible: Facilities Director	

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 1, 2016

Ms. Katie Lundmark, Administrator
Perham Living
735 Third Street Southwest
Perham, Minnesota 56573

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5486025

Dear Ms. Lundmark:

The above facility was surveyed on May 16, 2016 through May 19, 2016 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 one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Gail Anderson at (218) 332-5140 or email: gail.anderson@state.mn.us.**

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00438	A. BUILDING: _____ B. WING _____	05/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERHAM LIVING	735 THIRD STREET SOUTHWEST PERHAM, MN 56573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00438	A. BUILDING: _____ B. WING _____	05/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On May 16th, 17th, 18th and 19th 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00438	A. BUILDING: _____ B. WING _____	05/19/2016

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide appropriate maintenance to resident rooms numbered (404, 502, 507, 608, 610, 611, 713, 716). In addition, the facility failed to ensure resident rooms numbered (307 & 709) was kept clean and free of odors reviewed for environmental concerns. Findings include: On 5/19/16, from 11:30 a.m. to 11:46 a.m. a tour of the facility was completed with the environmental service director (ESD). The ESD verified the following resident room concerns: ·In room 307, toilet had a black substance which covered the entire area near the exit hole in the toilet bowl.	21685	Corrected	6/23/16

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	00438	A. BUILDING: _____ B. WING _____	05/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERHAM LIVING	735 THIRD STREET SOUTHWEST PERHAM, MN 56573

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21685	Continued From page 3 ·In room 404, bathroom walls gouged with missing paint near the bathroom door. ·In room 502, both corners in room had several areas by the bathroom door which were gouged and had missing paint. ·In room 507, room and bathroom walls had several areas with gouges and missing paint ·In room 608, bathroom walls gouged with missing paint near the door. ·In room 610, bathroom walls gouged with missing paint. In addition, the bathroom faucet had lime build up over the entire faucet. ·In room 611, bathroom walls gouged with missing paint. In addition, the bathroom faucet had lime build up over the entire faucet. ·In room 709, toilet had a reddish brown substance under the rim of the bowl, and the bathroom smelled of urine. ·In room 713, bathroom walls gouged near the toilet and door with missing paint. ·In room 716, bathroom walls gouged near the toilet and door with missing paint. The ESD confirmed resident rooms 307 and 709 lacked appropriate housekeeping. The ESD also confirmed the gouges identified in the rooms listed above were consistently large and obvious, average gouges measured 3-4"x 8-12." On 5/19/16, at 11:14 a.m. the ESD confirmed he had not received work orders requesting repairs for the above concerns identified. The ESD reported all staff were expected to notify the maintenance department when repairs were needed through the computerized maintenance request system. The ESD stated the maintenance department had not conducted any scheduled routine environmental walk through inspections of resident rooms and bathrooms.	21685		

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21685	Continued From page 4 No routine maintenance schedule for maintenance and up keep for resident rooms were provided. A facility maintenance policy was requested, but was not provided. SUGGESTED METHOD FOR CORRECTION: The administrator or designee could ensure all identified room concerns are corrected and monitored on an ongoing basis for good repair and resident satisfaction. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	21685		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to provide a dignified dining experience for 1 of 2 residents (R77) observed during breakfast in the Harvestglen neighborhood.	21805	Corrected.	6/23/16

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21805	Continued From page 5 Findings include: R77's quarterly Minimum Data Set (MDS) identified R77 was cognitively intact, independent with eating, and had diagnoses which included dementia and anxiety. R77's care plan, dated 3/8/16 identified R77 was at risk for impaired activities of daily living (ADL) function due to cognitive impairment due to impaired attention skills. The careplan further identified R77 was able to feed herself after set up, preferred to sit in the dining room, and staff were to encourage R77 to socialize and interact with table mates during meals. R77's Care Area Assessment (CAA), dated 9/16/15 identified R77 had dementia, mental health problems, weakness and difficulty expressing her ideas and wants because of her confusion and slowed thought process. The CAA indicated R77 required supervision at meals so she continued the task of eating, had disorganized thought processes and couldn't complete a task she had started. The CAA also identified R77 had dementia which interfered with eating due to short attention span which included slow eating and drinking. On 5/19/16, at 11:06 a.m. R47 and R77 were seated together at a dining room table in front of the kitchenette area of the Harvestglen neighborhood. The kitchenette area was open to the dining room, with the area both audible and visible to R47 and R77. Nursing assistant(NA)-A stood at the kitchenette counter, washing dishes at the sink when dietary aide (DA)-A walked from the dining room into the entryway of the kitchenette. DA-A stood in the entry way, less	21805		

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21805	Continued From page 6	21805		

than 10 feet from R77, who remained seated at the table and stated in a loud and harsh voice, "Is she still eating?, are you kidding me?" DA-A proceeded to walk into the pantry of the kitchenette and closed the door. R77 remained seated at the table of the kitchenette dining room with R47.

On 5/19/16, at 11:08 a.m. NA-A identified the residents in the dining room as R47 and R77, and confirmed DA-A made the loud, harsh remarks about R77. NA-A confirmed DA-A stood in the same area as R77 when DA-A made the harsh, loud comments, and stated she felt DA-A had not been respectful towards R77. NA-A indicated she felt DA-A had not treated R77 in a dignified manner when she made the comments about R77 out loud.

On 5/19/16, at 11:11 a.m. DA-A stated R77 had been in the dining room for quite awhile today. DA-A stated R77 sometimes took a long time to eat and the time depended on how she was doing on that day. DA-A confirmed R47 had just came out to breakfast, and her comments identified R77. DA-A confirmed her comments were not dignified, and confirmed R77 could have heard her make the negative remarks.

On 5/19/16, at 11:20 a.m. registered nurse clinical coordinator (RNCC-A) stated R77 was a "cute little putsy lady." She stated R77 took a long time to eat and sometimes R77 couldn't focus. She stated she felt staff speaking harsh, loud, negative comments about a resident was a dignity concern, and if family had been present, they could have heard the negative remarks also. She stated she expected staff to keep those type of conversations to themselves, or to share in a private area only. She stated she felt DA-A's

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21805	Continued From page 7 remarks were undignified. On 5/19/16, at 4:18 p.m. R77 stated she had to fill out her own paper menu by hand routinely before dietary gave her the meal she had chosen. She stated it took her awhile to write down what she wanted to eat because she was a slow thinker. She stated she liked breakfast, and it was her best meal of the day in terms of amount of food eaten by her compared to the other 2 meals. On 5/19/16, at 4:39 p.m. DON stated when employees were hired the staff received dignity training and were told of the facility expectations regarding dignity and how to treat residents at that time. She stated staff knew her expectations for resident treatment, and this was not common practice. She stated she expected staff to treat residents as they would like to be treated themselves. Upon review of the facilities core values provided by the DON, undated, identified under the core value of respect staff were to display a high regard and consideration for the dignity and uniqueness of everyone. SUGGESTED METHOD FOR CORRECTION: The administrator or designee could educate staff regarding dignified resident care. The quality assessment and assurance committee could perform random audits to ensure resident/staff interactions are appropriate and facility is in compliance. TIME PERIOD FOR CORRECTION: Fourteen	21805		

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21805	Continued From page 8 (14) days.	21805		