DEPARTMENT OF HEALT	<b>FH AND HUMA</b>	N SERVICES			CENTERS FOR MED	ICARE & MEDICAID SERVICES
					ND TRANSMITTAL	ID: 0H11
	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00438
1. MEDICARE/MEDICAID PROVID (L1) 245486	DER NO.	3. NAME AND AI (L3) <b>PERHAM L</b>		CILITY		<ol> <li>TYPE OF ACTION: <u>7(L8)</u></li> <li>Initial</li> <li>Recertification</li> </ol>
2.STATE VENDOR OR MEDICAID	NO.	(L4) 735 THIRD STREET SOUTHWEST			3. Termination4. CHOW	
(L2) <b>847242400</b>		(L5) PERHAM, 1	MN		(L6) <b>56573</b>	5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEG	ORY	<u>02</u> (L7)	
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 07/1	<b>2/2016</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATIO	DN	10.THE FACILITY	Y IS CERTIFIED	AS:		
From (a):		A. In Complia	ance With		And/Or Approved Waivers Of	The Following Requirements:
To (b) :		Program R	equirements		2. Technical Personnel	6. Scope of Services Limit
		Complianc	e Based On:		3. 24 Hour RN	7. Medical Director
12. Total Facility Beds	96 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	F) 8. Patient Room Size
13.Total Certified Beds	<b>96</b> (L17)	B Not in Comm	bliance with Progra	am	5. Life Safety Code	9. Beds/Room
13. Total Certified Beds			and/or Applied V		* Code: A*	(L12)
14. LTC CERTIFIED BED BREAKD	OWN	I			15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
96						
(L37) (L38)	(L39)	(L42)	(L43)			
16 OTATE CLIDVEN A CENCY DEN			ANCELLATION	DATE).		
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	BLE SHOW LIC CA	ANCELLAI ION I	DALE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
		Date .				
Gail Anderson, Uni	t Supervisor	0	07/21/2016	(1.10)	Mark meath	, Enforcement Specialist 08/30/2016
DA				(L19)	OFFICE OD SINCLE S	(L20)
					OFFICE OR SINGLE S	IATE AGENCY
19. DETERMINATION OF ELIGIBI	ILITY		IPLIANCE WITH HTS ACT:	I CIVIL		cial Solvency (HCFA-2572) l Interest Disclosure Stmt (HCFA-1513)
X 1. Facility is Eligible to	Participate	KIOI	IIISACI.		<ol> <li>3. Both of the Above</li> </ol>	
2. Facility is not Eligib						
	(L21)					
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	1ENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	6 DATE	ENDING DAT	ГЕ	VOLUNTARY 00	INVOLUNTARY
07/01/1987					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ment 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS	× /		03-Risk of Involuntary Termination	n OTHER
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(1.27)			(L44)			00-Active
(L27)	B. Rescind Su	spension Date:				
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	DETERMINATION	N OF APPROVAL	DATE		
	(L32)	06/30/2016		(L33)	DETERMINATION APPR	ROVAL



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



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,

Mart meeth

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	MULTIPLE CONSTRUCTION A. Building		DATE OF REVISIT	
245486 <sub>Y1</sub>	B. Wing	Y2	7/12/2016	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).

ITE	M	DATE	ITEM		DATE	ITEM	DATE	
Y4		Y5	Y4		Y5	Y4	Y5	
ID Prefix Reg. # LSC	F0241 483.15(a)	Correction Completed 06/23/2016	ID Prefix F046 Reg. # LSC		Correction Completed 06/23/2016	ID Prefix Reg. # LSC	Correc	
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correc	
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correc	
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction	ID Prefix Reg. # 	Correc	
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction	ID Prefix Reg. # LSC	Correc	
REVIEWE STATE AG REVIEWE CMS RO		REVIEWED BY (INITIALS) GA/mm REVIEWED BY (INITIALS)			2803	S. WAS A SUMMARY OF	DATE 28034	
5/19/2010	6		UNCORREC	CTED DEFICIENCIES	(CMS-2567) SEN <sup>-</sup>	T TO THE FACILITY?	YES	NO

# **POST-CERTIFICATION REVISIT REPORT**

	_				-
PROVIDER / SUPPLIER / CLIA /		MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER		A. Building 01 - 1970 BUILDING			
245486	Y1	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).

ITE	M	DATE	ITEM		DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix	 NFPA 101	Correction	ID Prefix	A 101	Correction	ID Prefix	 NFPA 101		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC	K0018	06/23/2016		9	06/23/2016	LSC	K0038		06/23/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	A 101	Completed	Reg. #	NFPA 101		Completed
LSC	K0046	06/23/2016	LSC K005	50	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			
REVIEWE STATE AG		REVIEWED BY (INITIALS) TL/mm	<b>DATE</b> 07/21/2016	SIGNATURE OF SU		536		<b>DATE</b> 06/27	7/2016
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
FOLLOW	UP TO SURVEY CO	DMPLETED ON		OR ANY UNCORRECTE					6 🗌 NO

# **POST-CERTIFICATION REVISIT REPORT**

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

ITE	M	DATE	ITEM	DATE	ITE	Λ	DATE
Y4		Y5	Y4	Y5	Y4		Y5
ID Prefix Reg. # LSC	NFPA 101 K0018	Correction Completed 06/23/2016	ID Prefix Reg. # NFPA · LSC K0046	06/23/20	eted Reg. #	ix	Correction Completed 06/23/2016
ID Prefix Reg. # LSC	NFPA 101 K0062	Correction Completed 06/23/2016	ID Prefix Reg. # LSC	Correct		ix	Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correct		ix	Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correct		ix	Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correct		ix	Correction Completed
REVIEWE STATE AG REVIEWE CMS RO FOLLOWI 5/17/2010	BENCY X D BY UP TO SURVEY CO	REVIEWED BY (INITIALS) TL/mm REVIEWED BY (INITIALS) DMPLETED ON		SIGNATURE OF SURVEYOR TITLE ANY UNCORRECTED DEFICI TED DEFICIENCIES (CMS-256	36536 ENCIES. WAS A S		DATE 06/27/2016 DATE

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

				AND TRANSMITTAL ID: 0H11 TE SURVEY AGENCY Facility ID: 0043		
1. MEDICARE/MEDICAID PROVIDER N           (L1)         245486           2.STATE VENDOR OR MEDICAID NO.         (L2)           847242400	0.	3. NAME AND ADE (L3) <b>PERHAM LF</b> (L4) <b>735 THIRD S</b> (L5) <b>PERHAM, M</b>	VING TREET SOUTHV		(L6) <b>56573</b>	4. TYPE OF ACTION:     2 (L8)       1. Initial     2. Recertification       3. Termination     4. CHOW       5. Validation     6. Complaint
<ol> <li>5. EFFECTIVE DATE CHANGE OF OW (L9)</li> <li>6. DATE OF SURVEY 05/19</li> </ol>		<ul> <li>7. PROVIDER/SUP.</li> <li>01 Hospital</li> <li>02 SNF/NF/Dual</li> </ul>	PLIER CATEGORY 05 HHA 06 PRTF	09 ESRD 10 NF	<u>02</u> (L7) 13 PTIP 22 CLIA 14 CORF	7. On-Site Visit 9. Other 8. Full Survey After Complaint
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC		FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION         From       (a) :         To       (b) :         12. Total Facility Beds         13. Total Certified Beds         14. LTC CERTIFIED BED BREAKDOWN         18 SNF       18/19 SNF         96         (L37)       (L38)         16. STATE SURVEY AGENCY REMARK	96 (L18) 96 (L17) 19 SNF (L39) S (JE APPLICABLE S	X B. Not in Comp Requirements a ICF (L42)	ce With uirements Based On: cceptable POC liance with Program nd/or Applied Waive IID (L43)	<u>rs:</u>	And/Or Approved Waivers Of TI          2. Technical Personnel          3. 24 Hour RN          4. 7-Day RN (Rural SNI          5. Life Safety Code           * Code:         B*           15. FACILITY MEETS           1861 (e) (1) or 1861 (j) (1):	e Following Requirements: 6. Scope of Services Limit 7. Medical Director 8. Patient Room Size 9. Beds/Room (L12) (L15)
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY A	PPROVAL Date:
Sherri Softing, HPS SW	S	0	6/15/2016	(L19)	Mark Meath,	Enforcement Specialist06/30/2016 (L20)
	PART II - TO	BE COMPLETEI	) BY HCFA RE	. ,	OFFICE OR SINGLE STA	. ,
19. DETERMINATION OF ELIGIBILITY        1. Facility is Eligible to Part        2. Facility is not Eligible		20. COM	N LANCE WITH CI			
	(L21)	RIGH	TS ACT:	VIL		cial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513) :
22. ORIGINAL DATE					2. Ownership/Contro	I Interest Disclosure Stmt (HCFA-1513)
OF PARTICIPATION <b>07/01/1987</b>	(L21) 23. LTC AGREEM BEGINNING	ENT 2-	TS ACT: 4. LTC AGREEMEN ENDING DATE	NT	2. Ownership/Contro     3. Both of the Above      26. TERMINATION ACTION: <u>VOLUNTARY</u> 01-Merger, Closure	I Interest Disclosure Stmt (HCFA-1513)           :           (L30)           10           INVOLUNTARY           05-Fail to Meet Health/Safety
OF PARTICIPATION 07/01/1987 (L24) 25. LTC EXTENSION DATE:	(L21) 23. LTC AGREEM BEGINNING (L41) 27. ALTERNATIV A. Suspension	ENT 24 DATE E SANCTIONS of Admissions:	TS ACT: 4. LTC AGREEMEN	NT	2. Ownership/Contro     3. Both of the Above     26. TERMINATION ACTION: <u>VOLUNTARY</u>	I Interest Disclosure Stmt (HCFA-1513)           :           (L30)           10           INVOLUNTARY           05-Fail to Meet Health/Safety
OF PARTICIPATION <b>07/01/1987</b> (L24)	(L21) 23. LTC AGREEM BEGINNING (L41) 27. ALTERNATIV	ENT 24 DATE E SANCTIONS of Admissions:	TS ACT: 4. LTC AGREEMEN ENDING DATE (L25)	NT	2. Ownership/Contro     3. Both of the Above      26. TERMINATION ACTION: <u>VOLUNTARY</u> 01-Merger, Closure      02-Dissatisfaction W/ Reimbursem      03-Risk of Involuntary Termination	I Interest Disclosure Stmt (HCFA-1513) : (L30) 10 INVOLUNTARY 05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement OTHER 07-Provider Status Change
OF PARTICIPATION 07/01/1987 (L24) 25. LTC EXTENSION DATE:	(L21) 23. LTC AGREEM BEGINNING (L41) 27. ALTERNATIV A. Suspension B. Rescind Sus	ENT 24 DATE E SANCTIONS of Admissions:	TS ACT: 4. LTC AGREEMEN ENDING DATE (L25) (L44) (L45)	NT	2. Ownership/Contro     3. Both of the Above      26. TERMINATION ACTION: <u>VOLUNTARY</u> 01-Merger, Closure      02-Dissatisfaction W/ Reimbursem      03-Risk of Involuntary Termination	I Interest Disclosure Stmt (HCFA-1513) : (L30) 10 INVOLUNTARY 05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement OTHER 07-Provider Status Change
OF PARTICIPATION 07/01/1987 (L24) 25. LTC EXTENSION DATE: (L27)	(L21) 23. LTC AGREEM BEGINNING (L41) 27. ALTERNATIV A. Suspension B. Rescind Sus 25	ENT 24 DATE E SANCTIONS of Admissions: pension Date:	TS ACT: 4. LTC AGREEMEN ENDING DATE (L25) (L44) (L45)	۹۲.	2. Ownership/Contro     3. Both of the Above      26. TERMINATION ACTION: <u>VOLUNTARY</u> 01-Merger, Closure      02-Dissatisfaction W/ Reimbursem      03-Risk of Involuntary Termination      04-Other Reason for Withdrawal	I Interest Disclosure Stmt (HCFA-1513) : (L30) 10 INVOLUNTARY 05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement OTHER 07-Provider Status Change
OF PARTICIPATION 07/01/1987 (L24) 25. LTC EXTENSION DATE: (L27)	(L21) 23. LTC AGREEM BEGINNING (L41) 27. ALTERNATIV A. Suspension B. Rescind Sus 25 (L28)	ENT 2- DATE E SANCTIONS of Admissions: pension Date: . INTERMEDIARY/C/	TS ACT: 4. LTC AGREEMEN ENDING DATE (L25) (L44) (L45) ARRIER NO.	NT (L31)	2. Ownership/Contro     3. Both of the Above      26. TERMINATION ACTION: <u>VOLUNTARY</u> 01-Merger, Closure      02-Dissatisfaction W/ Reimbursem      03-Risk of Involuntary Termination      04-Other Reason for Withdrawal	I Interest Disclosure Stmt (HCFA-1513) : (L30) 10 INVOLUNTARY 05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement OTHER 07-Provider Status Change



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:

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

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

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

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

<u>Informal Dispute Resolution</u> - 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

S FOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT		. 0938-0391			
		(X2) MULT					
	IDENTIFICATION NUMBER:			E SURVEY IPLETED			
	245486	B. WING _		19/2016			
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
LIVING			735 THIRD STREET SOUTHWEST PERHAM, MN 56573				
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
INITIAL COMMENT	S	F 00	00				
as your allegation o Department's accept enrolled in ePOC, y at the bottom of the form. Your electron	f compliance upon the btance. Because you are our signature is not required first page of the CMS-2567 ic submission of the POC will						
on-site revisit of you validate that substa regulations has bee your verification.	ar facility may be conducted to ntial compliance with the n attained in accordance with	F 24	11	6/23/16			
manner and in an e enhances each resi	nvironment that maintains or dent's dignity and respect in						
by: Based on observat review the facility fa dining experience fo observed during bre neighborhood. Findings include: R77's quarterly Min identified R77 was o with eating, and had	ion, interview and record iled to provide a dignified or 1 of 2 residents (R77) eakfast in the Harvestglen imum Data Set (MDS) cognitively intact, independent d diagnoses which included		educational session on what it means to speak and act in a professional and dignified manner. This includes a				
	(EACH DEFICIENCY REGULATORY OR LS INITIAL COMMENT The facility's plan of as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an a on-site revisit of you validate that substa regulations has beet your verification. 483.15(a) DIGNITY INDIVIDUALITY The facility must pro- manner and in an e enhances each resis full recognition of hi This REQUIREMEN- by: Based on observat review the facility fa dining experience for observed during bre- neighborhood. Findings include: R77's quarterly Min- identified R77 was of with eating, and had dementia and anxie	PROVIDER OR SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         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.         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.	PROVIDER OR SUPPLIER       ID         ILIVING       ID         ILIVING       ID         IREGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX         INITIAL COMMENTS       F 00         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.         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	ROVIDER OR SUPPLER       STREET ADDRESS, CITY, STATE, ZIP CODE         ILIVING       735 THIRD STREET SOUTHVEST         PERHAM, MN 56573       PERHAM, MN 56573         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ON LSC DENTIFYING INFORMATION)       PROVIDERS PLAN OF CORRECTION (EACH ODERCTIVE ACTION SHOULD BE PRECEDED BY FULL REGULATORY ON LSC DENTIFYING INFORMATION)         INITIAL COMMENTS       F 000         The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in POC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your relectronic submission of the POC will be used as verification of compliance.       F 000         Upon receipt of an acceptable electronic POC, an an-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 241         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.       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 speak ing in a professional and dignified manner. This includes a presentation of our core values and facility wide expectations and an inclusive			

**Electronically Signed** 

06/09/2016

PRINTED: 06/15/2016

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.

#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245486 **B** WING 05/19/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 735 THIRD STREET SOUTHWEST PERHAM LIVING PERHAM, MN 56573 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 241 Continued From page 1 F 241 R77's care plan, dated 3/8/16 identified R77 was discussion on how staff can improve and at risk for impaired activities of daily living (ADL) maintain their professionalism in the function due to cognitive impairment due to workplace while also keeping close impaired attention skills. The careplan further relationships with residents. This identified R77 was able to feed herself after set education will be brought to staff within the organization. Registered Nurse. up, preferred to sit in the dining room, and staff were to encourage R77 to socialize and interact LPN s, Nursing Assistants, Household with table mates during meals. Coordinators, Social Services, Administrator, DON, Dietary, Laundry, R77's Care Area Assessment (CAA), dated Housekeeping and Environmental 9/16/15 identified R77 had dementia, mental Services. health problems, weakness and difficulty The educational of all staff will be expressing her ideas and wants because of her completed by 6/23/2016. Review of core confusion and slowed thought process. The CAA values and policies will also occur to indicated R77 required supervision at meals so ensure alignment with organizational she continued the task of eating, had goals. disorganized thought processes and couldn't Ongoing monitoring and random audits complete a task she had started. The CAA also will occur to ensure resident/staff interactions are professional and dignified identified R77 had dementia which interfered with eating due to short attention span which included to remain in compliance. It will be slow eating and drinking. reviewed at the Quality Assurance Committee for ongoing quality assurance of the process. The QA Committee will On 5/19/16, at 11:06 a.m. R47 and R77 were seated together at a dining room table in front of determine ongoing needs. the kitchenette area of the Harvestglen Persons responsible include Director of Nutrition Services, Director of Nursing and neighborhood. The kitchenette area was open to the dining room, with the area both audible and Administrator or designee. 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 2 of 6

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	06/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	E SURVEY PLETED
		245486	B. WING		05/ <sup>-</sup>	19/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PERHAM	LIVING			735 THIRD STREET SOUTHWEST PERHAM, MN 56573		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 241	Continued From pa	ge 2	F 241			
	residents in the dini confirmed DA-A ma about R77. NA-A co same area as R77 loud comments, and been respectful tow felt DA-A had not tro manner when she r R77 out loud. On 5/19/16, at 11:1 been in the dining r DA-A stated R77 s eat and the time de on that day. DA-A co out to breakfast, an R77. DA-A confirmed dignified, and confir her make the negat On 5/19/16, at 11:2 coordinator (RNCC little putsy lady." Sh to eat and sometim stated she felt staff negative comments dignity concern, and they could have hea She stated she exp of conversations to private area only. S remarks were undig	0 a.m. registered nurse clinical -A) stated R77 was a "cute e stated R77 took a long time es R77 couldn't focus. She speaking harsh, loud, a about a resident was a d if family had been present, ard the negative remarks also. ected staff to keep those type themselves, or to share in a he stated she felt DA-A's gnified.				
	out her own paper r dietary gave her the	p.m. R77 stated she had to fill menu by hand routinely before e meal she had chosen. She while to write down what she				

If continuation sheet Page 3 of 6

		AND HUMAN SERVICES			FORM	06/15/2016 APPROVED
STATEMENT	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CI PLE CONSTRUCTION	(X3) DATE	0938-0391 E SURVEY PLETED
		245486	B. WING		05/ <sup>-</sup>	19/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PERHAM	I LIVING			735 THIRD STREET SOUTHWEST PERHAM, MN 56573		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241 F 465 SS=E	wanted to eat becau She stated she like best meal of the day eaten by her compa On 5/19/16, at 4:39 employees were hir training and were to regarding dignity at that time. She stated for resident treatme practice. She stated residents as they we themselves. Upon review of the by the DON, undate value of respect sta regard and conside uniqueness of every 483.70(h) SAFE/FUNCTIONA E ENVIRON The facility must pro sanitary, and comfor residents, staff and This REQUIREMEN by: Based on observat review, the facility fa maintenance to res 502, 507, 608, 610, the facility failed to numbered (307 & 7	use she was a slow thinker. d breakfast, and it was her y in terms of amount of food ared to the other 2 meals. p.m. DON stated when red the staff received dignity old of the facility expectations nd how to treat residents at ed staff knew her expectations ent, and this was not common d she expected staff to treat rould like to be treated facilities core values provided ed, identified under the core aff were to display a high eration for the dignity and yone. AL/SANITARY/COMFORTABL	F 24		ere of ooms	6/23/16

Facility ID: 00438

If continuation sheet Page 4 of 6

		AND HUMAN SERVICES			FORM	06/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245486	B. WING		05/1	19/2016
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PERHAM	LIVING			35 THIRD STREET SOUTHWEST PERHAM, MN 56573		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	REGULATORY OR LE Continued From par Findings include: On 5/19/16, from 1° of the facility was contended environmental serve The ESD verified the concerns: ·In room 307, toilet covered the entire at toilet bowl. ·In room 404, bathread in room 502, both areas by the bathroon gouged and ·In room 507, room several areas with g ·In room 608, bathread missing paint near ·In room 610, bathread missing paint. In an had lime build up ov ·In room 709, toilet substance under th bathroom smel	age 4 1:30 a.m. to 11:46 a.m. a tour ompleted with the ice director (ESD). the following resident room had a black substance which area near the exit hole in the room walls gouged with the bathroom door. corners in room had several bom door which were thad missing paint. and bathroom walls had gouges and missing paint room walls gouged with the door. room walls gouged with the door. room walls gouged with ddition, the bathroom faucet ver the entire faucet. oom walls gouged with ddition, the bathroom faucet ver the entire faucet. had a reddish brown the rim of the bowl, and the led of urine.		CROSS-REFERENCED TO THE APPROPR	RIATE Ince le es, iluding semi- udits ooms in good at the ingoing he QA needs. mpleted iled by	
	toilet and door with ·In room 716, bathr toilet and door with The ESD confirmed lacked appropriate confirmed the goug	oom walls gouged near the				

If continuation sheet Page 5 of 6

		AND HUMAN SERVICES			FORM	: 06/15/2016 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245486	B. WING		05/	19/2016
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
PERHAM	I LIVING			735 THIRD STREET SOUTHWEST PERHAM, MN 56573		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 465		easured 3-4"x 8-12."	F 46	5		
	had not received we for the above conce reported all staff we maintenance depar needed through the request system. The maintenance depar scheduled routine e	4 a.m. the ESD confirmed he ork orders requesting repairs erns identified. The ESD ere expected to notify the tment when repairs were e computerized maintenance he ESD stated the tment had not conducted any environmental walk through lent rooms and bathrooms.				
	No routine mainten maintenance and u were provided.	ance schedule for p keep for resident rooms				
	A facility maintenan was not provided.	ce policy was requested, but				

Facility ID: 00438

If continuation sheet Page 6 of 6

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>I `</b> <i>'</i>	PLE CONSTRUCTION G 01 - 1970 BUILDING		TE SURVEY MPLETED
IND FLAN O	CONNECTION		~	3 01 - 1970 BOILDING		4710040
		245486	B. WING	STREET ADDRESS, CITY, STATE, ZIP CO		/17/2016
NAME OF F	ROVIDER OR SUPPLIER			735 THIRD STREET SOUTHWEST		
PERHAM	LIVING			PERHAM, MN 56573		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	ſS	K 00	0		
	FIRE SAFETY					
	01 1970 Building a	nd 1979 addition				
	ALLEGATION OF ( DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE ATION OF COMPLIANCE.				
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CC REGULATIONS H	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.		IJ		
	Minnesota Departr Fire Marshal Divisi Perham Memorial found not in substa requirements for p Medicare/Medicaic 483.70(a), Life Saf edition of National	l at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),		EPOC		
	PLEASE RETURN CORRECTION FO DEFICIENCIES TO	OR THE FIRE SAFETY				
	HEALTH CARE FI STATE FIRE MAR	RE INSPECTIONS SHAL DIVISION	0			

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.

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		E SURVEY	
ND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01 - 1970 BUILDING			
		245486	B. WING		05/	17/2016	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 735 THIRD STREET SOUTHWEST PERHAM, MN 56573				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE	
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the defic 2. The actual, or pr 3. The name and/or responsible for cor- prevent a reoccurre This facility was su- buildings: Perham Memorial different times. The building constructed to be of Type II(000 1-story with a base west of the original to be of Type II(222) building addition is barrier. These 2 bu- renovated in 2006. basement was add 1970 building and II(222) construction	ET, SUITE 145 01-5145, or tate.mn.us n@state.mn.us RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done	K 000				

Facility ID: 00438

If continuation sheet Page 2 of 8

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	06/16/2016 APPROVED 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION 01 - 1970 BUILDING		E SURVEY PLETED
		245486	B. WING		05/1	17/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PERHAN	I LIVING			35 THIRD STREET SOUTHWEST PERHAM, MN 56573		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000 K 018 SS=E	The facility is comp automatic fire sprin accordance with NI Installation of Sprin The facility has a fin detectors in the cor corridors and in all monitored for autor notification and inst 72 "The National Fi All areas requiring accordance with th (MSFC) 2007 edition The facility has a car census of 91 at the The requirement at NOT MET as evide NFPA 101 LIFE SA Doors protecting cor required enclosure hazardous areas s as those constructor core wood, or capa 20 minutes. Cleara and floor covering in fully sprinklered required to resist th no impediment to to open devices that in pushed or pulled a provided with a me door closed. Dutch permitted. Door fra- made of steel or ot	letely protected by an kler system installed in FPA 13 Standard for the kler Systems 1999 edition. re alarm system with smoke ridors, spaces open to the resident rooms that is natic fire department talled in accordance with NFPA ire Alarm Code" 1999 edition. automatic fire detection in e Minnesota State Fire Code on have been installed. apacity of 96 beds and had a e time of the survey.	К 000			6/23/16

Event ID: 0H1121

Facility ID: 00438

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		& MEDICAID SERVICES			OMB NO.	and a second
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 01 - 1970 BUILDING		E SURVEY PLETED
		245486	B. WING _		05/	17/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PERHAN	LIVING			735 THIRD STREET SOUTHWEST PERHAM, MN 56573		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
K 018	Continued From pa	nge 3	K 0	18		
		all health care facilities.				
	Based on observar facility failed to mai 3 corridor doors ac section 19.3.6.3.1. affect the safety of undetermined amo	s not met as evidenced by: tion and staff interview, the ntain the smoke resistance of cording to NFPA 101 LSC (00) This deficient practice could 17 of the 91 residents and an unt of staff and visitors, if were allowed to enter the exit aking it untenable.		K018 Doors 306, 307 and Transitions room doors will be corrected to securely. All doors in the facility monitored on a semi-annual ba identify, detect, correct all other may exhibit this issue. Complet 6/23/2016. Person Responsible Director	latch will sis to doors that ed by	
	Findings include:					
	on 05/17/2016 obs revealed the follow latching doors that 1. Two resident roo existing building	between 7:45 am to 1:30 pm ervations and staff interview <i>v</i> ing rooms did not have open to the corridor. om doors (306 & 307) in the door of the transition wing in g.				
K 029 SS=D	Administrator and t NFPA 101 LIFE SA One hour fire rated fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro the approved autor	ition was verified by the Facility the Maintenance Supervisor. FETY CODE STANDARD construction (with o hour an approved automatic fire m in accordance with 8.4.1 tects hazardous areas. When natic fire extinguishing system areas are separated from	κo	29		6/23/16
	other spaces by sm doors. Doors are s field-applied protec 48 inches from the permitted. 19.3.2 This STANDARD i	noke resisting partitions and self-closing and non-rated or tive plates that do not exceed bottom of the door are		К029	18	

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Event ID: 0H1121

Facility ID: 00438

If continuation sheet Page 4 of 8

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - 1970 BUILDING 245486 B. WING 05/17/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 735 THIRD STREET SOUTHWEST PERHAM LIVING PERHAM, MN 56573 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 029 Continued From page 4 K 029 Sheetrock will be added to the addition of facility failed to maintain smoke-resisting the identified area to cover the wall partitions and doors in 1 of the hazardous rooms penetrations. Fire caulking and seal to all in accordance with the following requirements of penetrations will occur as well in this area. 2000 NFPA 101, Section 19.3.2.1. The deficient A process is now implemented that practice could affect all staff and visitors using requires vendors that work in the facility that level. are required to have the work inspected and signed off prior to the ceiling tiles being replaced and the ceiling closed. Findings include: This will be reviewed in the semi-annual basis to the facility inspection process. On the facility tour between 7:45 am to 1:30 pm Completed by 6/23/2016. Person on 05/17/2016 observations and staff interview Responsible: Facilities Director revealed wall penetrations in the main laundry in the lower level. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor. 6/23/16 K 038 K 038 NFPA 101 LIFE SAFETY CODE STANDARD SS=D 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: K038 Based on observation and staff interview the The facility has a signed contract with facility failed to maintain 1 exits in accordance contractor to remove and replace the with the egress requirements of NFPA 101 Life sidewalk. Complete by 07/15/2016. This Safety Code (00) section 7.2.1.3, floor level. This sidewalk was marked with caution until decficient practice could affect the safe and replacement is complete. All facility efficient exiting of 15 of the 91 residents, staff and sidewalks will be inspected during semivisitors. annual inspection process. Person **Responsible: Facilities Director** 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00438

If continuation sheet Page 5 of 8

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - 1970 BUILDING 245486 B WING 05/17/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 735 THIRD STREET SOUTHWEST PERHAM LIVING PERHAM, MN 56573 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 038 Continued From page 5 K 038 This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor. 6/23/16 K 046 NFPA 101 LIFE SAFETY CODE STANDARD K 046 SS=F 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: K046 Based on observations and an interview with This issue was identified and corrected staff, the facility has failed to ensure that prior to the inspection. We now have this emergency lighting has been tested in on a maintenance prevention calendar accordance with NFPA LSC (00) Section 7.9, and have staff assigned to this process. 19.2.9.1. This deficient practice could affect all 91 Monitored monthly for review. This was residents, and an undetermined amount of staff corrected February 2016. Person and visitors in the event of an emergency Responsible: Facilities Director 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 guarter of 2015. This deficient condition was verified by the Facility Administrator and the Maintenance Supervisor. 6/23/16 K 050 NFPA 101 LIFE SAFETY CODE STANDARD K 050 SS=F 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

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0H1121

Facility ID: 00438

If continuation sheet Page 6 of 8

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION 01 - 1970 BUILDING		E SURVEY PLETED
		245486	B. WING		05/*	7/2016
AME OF	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
PERHAN	I LIVING			35 THIRD STREET SOUTHWEST PERHAM, MN 56573		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 050	instead of audible 18.7.1.2, 19.7.1.2 This STANDARD Based on record r was determined th fire drills in accord Code 101(00), 19. period. This deficie staff react in the ev by staff would affec and undetermined Findings include: On the facility tour on 05/17/2016 recorrevealed in the last records that the for conducted. 1. One drill in the	nnouncement may be used	К 050	K050 This issue was identified and corr prior to the inspection. We now h on a fire drill calendar and have s assigned to this process. Monitor monthly for review to assure com This was corrected February 201 added the name of the person at alarm facility for documentation o contact at the alarm center. We a have added the alerts to the Faci Director and the Safety Director f alarms that are received by the a company. Person Responsible: F Director	ave this taff red pletion. 6. We the f the also ity or any arm	
K 062 SS=F	Administrator and NFPA 101 LIFE SA Required automatic continuously maint condition and are in periodically. 19. 9.7.5 This STANDARD Based on docume with staff, the facilit and maintain the a accordance with N Section 19.7.6, an	Area of the second state of the facility the Maintenance Supervisor. AFETY CODE STANDARD c sprinkler systems are tained in reliable operating nspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25, is not met as evidenced by: entation review and interview ity has failed to properly inspect nutomatic sprinkler system in IFPA 101 Life Safety Code (00), d 4.6.12, NFPA 13 Installation ns (99), and NFPA 25 Standard	K 062	K062 This issue was identified and cor prior to the inspection. We now l on a maintenance prevention cal and have staff assigned to this p Monitored monthly for review to a completion. This was corrected F	nave this endar rocess. assure	6/23/16

Facility ID: 00438

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/16/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ISTRUCTION 970 BUILDING	(X3) DAT CON	E SURVEY IPLETED
		245486	B. WING			05/	17/2016
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
PERHAM	I LIVING				IRD STREET SOUTHWEST AM, MN 56573		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 062	Water Based Fire F deficient practice de sprinkler system is fully operational in to negatively affect all undtermined amount Findings include: On the facility tour for on 05/17/2016 reco revealed in the last records of the quar third and fourth quar	Protection Systems, (98). This bes not ensure that the fire functioning properly and is the event of a fire and could 91 residents and an nt of staff and visitors. between 7:45 am to 1:30 pm ord review and staff interview 12 months there were no terly sprinkler tests for the	K		16. Person Responsible: Fac ector	silities	
FORM CMS-2	567(02-99) Previous Versions	s Obsolete Event ID: 0H112	1	Facility ID	D: 00438 If ct	ontinuation sh	eet Page 8 of 8

		AND HUMAN SERVICES & MEDICAID SERVICES	-	F	010100	FORM	: 06/16/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION 02 - 2005 BUILDING		E SURVEY IPLETED
		245486	B: WING	;		05/	/17/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PERHAN	I LIVING				735 THIRD STREET SOUTHWEST PERHAM, MN 56573		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS	K	000			
	FIRE SAFETY						
	02 2005 Building						
	ALLEGATION OF ( DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.					
i.	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					,
	Minnesota Departm Fire Marshal Divisio Perham Memorial I found not in substa requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National	at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),			FPOC	7	
	PLEASE RETURN CORRECTION FO DEFICIENCIES TO	R THE FIRE SAFETY					
	HEALTH CARE FIR STATE FIRE MARS						
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
Electron	nically 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.

		AND HUMAN SERVICES				FORMA	06/16/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION 02 - 2005 BUILDING	(X3) DATE COMF	SURVEY
		245486	B. WING	i		05/1	7/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
PERHAN	1 LIVING			l .	35 THIRD STREET SOUTHWEST PERHAM, MN 56573		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
К 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the defici 2. The actual, or pr 3. The name and/o responsible for com prevent a reoccurre This facility was sur buildings: Perham Memorial I different times. The building constructed to be of Type II(000 1-story with a base west of the original to be of Type II(000 1-story with a base west of the original to be of Type II(222 building addition is barrier. These 2 bur renovated in 2006. basement was add 1970 building and v II(222) construction	ET, SUITE 145 01-5145, or tate.mn.us m@state.mn.us RRECTION FOR EACH TINCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. rveyed as 2 separate Home was constructed at 3 e original building, a 1-story d in 1970 and was determined 0) construction. In 1979, a ment was added to the south building and was determined 2) construction. However, the not separated by a 2-hour fire iildings were completely In 2005 a 2-story building with ed to the north west of the was determined to be of Type n. The building is divided into 8 nts by 30- minute, 1- hour and	K	000			

Facility ID: 00438

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL		(X3) DATE	0938-039
ND PLAN C		IDENTIFICATION NUMBER:	A. BUILDING	02 - 2005 BUILDING	COMP	PLETED
		245486	B. WING		05/17/2016	
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
PERHAN	LIVING	<i>b</i>		35 THIRD STREET SOUTHWEST ERHAM, MN 56573		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa	age 2	K 000			
	The facility is comp automatic fire sprin accordance with NI Installation of Sprin The facility has a fin detectors in the con corridors and in all monitored for autor notification and inst 72 "The National F All areas requiring accordance with th (MSFC) 2007 edition	oletely protected by an okler system installed in FPA 13 Standard for the okler Systems 1999 edition. re alarm system with smoke rridors, spaces open to the resident rooms that is matic fire department talled in accordance with NFPA ire Alarm Code" 1999 edition. automatic fire detection in e Minnesota State Fire Code on have been installed. apacity of 96 beds and had a e time of the survey.				
K 018 SS=E	NOT MET as evide NFPA 101 LIFE SA Doors protecting co constructed to resis Clearance betweer covering is not exc impediment to the devices that releas pulled are permitte positive latching ha 18.3.6.3.6 are perm prohibited. 18.3.6.3 This STANDARD	FETY CODE STANDARD orridor openings shall be st the passage of smoke. In bottom of door and floor eeding 1 inch. There is no closing of the doors. Hold open e when the door is pushed or d. Doors shall be provided with ardware. Dutch doors meeting nitted. Roller latches shall be	K 018	1/018		6/23/16
	Based on observa facility failed to mai 3 corridor doors ac section 18.3.6.3.1.	tion and staff interview, the intain the smoke resistance of cording to NFPA 101 LSC (00) This deficient practice could 32 of the 91 residents and an	10	K018 Doors 613 will be corrected to latch securely. All doors in the facility will monitored on a semi-annual basis identify, detect, correct all other doo	to	

Event ID: 0H1121

Facility ID: 00438

If continuation sheet Page 3 of 6

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	. ,	02 - 2005 BUILDING	COMP	LETED
		245486	B. WING		05/1	7/2016
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PERHAN	I LIVING			35 THIRD STREET SOUTHWEST ERHAM, MN 56573		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIO DATE
K 018		unt of staff and visitors, if vere allowed to enter the exit	K 018	may exhibit this issue. Completed 6/23/2016. Person Responsible: F Director		
	on 05/17/2016 obso revealed the follow doors that open to 1. One resident roc addition. This deficient cond	m door (613) in the 2005 ition was verified by the Facility				
K 046 SS=F	NFPA 101 LIFE SA Emergency lighting is provided automa 18.2.9.1, 19.2.9.1. This STANDARD i Based on observa staff, the facility has emergency lighting accordance with NI 18.2.9.1. This defice residents, and an u	he Maintenance Supervisor. FETY CODE STANDARD of at least 1 1/2 hour duration tically in accordance with 7.9. s not met as evidenced by: tions and an interview with s failed to ensure that has been tested in FPA LSC (00) Section 7.9, ient practice could affect all 91 indetermined amount of staff event of an emergency a power outage.	K 046	K046 This issue was identified and corre prior to the inspection. We now ha on a maintenance prevention cale and have staff assigned to this pro Monitored monthly for review. Thi corrected February 2016. Person Responsible: Facilities Director	ected ave this ndar ocess.	6/23/16
	on 05/17/2016 reco	between 7:45 am to 1:30 pm ord review and staff interview gency lights were not tested in 015.				

Event ID: 0H1121

Facility ID: 00438

If continuation sheet Page 4 of 6

ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTIPLE	E CONSTRUCTION (X3)	DATE SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:		02 - 2005 BUILDING	COMPLETED
		245486	B. WING		05/17/2016
IAME OF F	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
PERHAN	I LIVING			85 THIRD STREET SOUTHWEST ERHAM, MN 56573	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETIOI E DATE
K 050 SS=F	Fire drills include th	FETY CODE STANDARD e transmission of a fire alarm on of emergency fire	K 050		6/23/16
	conditions. Fire drill times under varying on each shift. The s and is aware that dr routine. Responsibilit conducting drills is a persons who are qu Where drills are con 6:00 AM a coded and instead of audible at 18.7.1.2, 19.7.1.2 This STANDARD is Based on record re- was determined that fire drills in accordar Code 101(00), 18.7 period. This deficie staff react in the ev- by staff would affect and undetermined at Findings include: On the facility tour I on 05/17/2016 recor- revealed in the last records that the foll conducted. 1. One drill in the fa	as are held at unexpected o conditions, at least quarterly staff is familiar with procedures rills are part of established lity for planning and assigned only to competent ualified to exercise leadership. Inducted between 9:00 PM and nnouncement may be used and an anouncement may be used alarms. Is not met as evidenced by: eview and staff interview, it at the facility failed to conduct ince with NFPA Life Safety 7.1.2, during the last 12-month int practice could affect how ent of a fire. Improper reaction t the safety of all 91 residents amount of staff and visitors between 7:45 am to 1:30 pm ord review and staff interview 12 months there were no owing fire drills were		K050 This issue was identified and corrected prior to the inspection. We now have to on a fire drill calendar and have staff assigned to this process. Monitored monthly for review to assure completio 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 an alarms that are received by the alarm company. Person Responsible: Facilit Director	his on. e y
K 062 SS=F	NFPA 101 LIFE SA	he Maintenance Supervisor. FETY CODE STANDARD	K 062		6/23/16

Facility ID: 00438

If continuation sheet Page 5 of 6

		AND HUMAN SERVICES			FORM	06/16/2016 APPROVED
STATEMENT	S FOR MEDICARE OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG <b>02 - 2005 BUILDING</b>	(X3) DAT	0938-0391 E SURVEY PLETED
		245486	B. WING		05/	17/2016
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C		
				735 THIRD STREET SOUTHWEST		
				PERHAM, MN 56573		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
K 062	4.6.12, NFPA 13, N This STANDARD i Based on docume with staff, the facilit and maintain the au accordance with NI Section 18.7.6, and of Sprinkler System for the Inspection, Water Based Fire F deficient practice d sprinkler system is fully operational in negatively affect all undtermined amou Findings include: On the facility tour on 05/17/2016 reco revealed in the last records of the quar third and fourth quar	d periodically. 18.7.6, 19.7.6, IFPA 25, 9.7.5 s not met as evidenced by: ntation review and interview y has failed to properly inspect utomatic sprinkler system in FPA 101 Life Safety Code (00), 4.6.12, NFPA 13 Installation ns (99), and NFPA 25 Standard Testing and Maintenance of Protection Systems, (98). This oes not ensure that the fire functioning properly and is the event of a fire and could 191 residents and an nt of staff and visitors.	KO	62 K062 This issue was identified ar prior to the inspection. We on a maintenance preventia and have staff assigned to Monitored monthly for revise completion. This was corre 2016. Person Responsible: Director	now have this on calendar this process. we to assure cted February	
FORM CMS-2	567(02-99) Previous Versions	s Obsolete Event ID: 0H112	1	Facility ID: 00438	If continuation she	et Page 6 of 6



### 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 <u>only a suggestion</u> 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00438	B. WING		05/1	9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PERHAM	I LIVING		D STREET S MN 56573	OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 06/09/16

Electronically Signed

6899

If continuation sheet 1 of 9

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
00438		B. WING		05/	05/19/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
PERHAM	/ LIVING		ID STREET SO I, MN 56573	OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Department of Hea you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th corrected prior to e Minnesota Departm On May 16th, 17th surveyors of this De above provider and orders are issued. electronic plan of cor reviewed these ord they will be comple Minnesota Departm the State Licensing federal software. Ta assigned to Minness Nursing Homes. The assigned tag in column entitled "ID statute/rule out of co "Summary Stateme	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. , 18th and 19th 2016, epartment's staff, visited the I the following correction Please indicate in your orrection that you have ers, and identify the date wher				
	findings which are i after the statement evidence by." Follor	nis column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUMN "PROVIDER'S PLA	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/S AND PLAN OF CORRECTION IDENTIFICAT		A. BUILDING	:	COM	IPLETED
00438		00438	B. WING		05/19/2016	
IAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	•	
PERHAM	LIVING		D STREET S , MN 56573	SOUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
2 000	Continued From pa	ge 2	2 000			
	THIS WILL APPEA	R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
21685	MN Rule 4658.141 Housekeeping, Ope	5 Subp. 2 Plant eration, & Maintenance	21685			6/23/16
	including walls, floo systems, and equip continuous state of with regard to the h well-being of the re	blant. The physical plant, rs, ceilings, all furnishings, ment must be kept in a good repair and operation ealth, comfort, safety, and esidents according to a written e and repair program.				
	by: Based on observati review, the facility fa maintenance to res 502, 507, 608, 610, the facility failed to numbered (307 & 7	ent is not met as evidenced on, interview, and document ailed to provide appropriate ident rooms numbered (404, 611, 713, 716). In addition, ensure resident rooms 09) was kept clean and free of environmental concerns.		Corrected		
	Findings include:					
	On 5/19/16, from 1 of the facility was co environmental serv					
	concerns: ·In room 307, toilet	e following resident room had a black substance which area near the exit hole in the				

				E SURVEY PLETED		
00438			05/	19/2016		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
		JTHWEST				
CIENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
bathroom walls gouged with near the bathroom door. both corners in room had several bathroom door which were d and had missing paint. room and bathroom walls had with gouges and missing paint bathroom walls gouged with near the door. bathroom walls gouged with In addition, the bathroom fauced up over the entire faucet. bathroom walls gouged with In addition, the bathroom fauced up over the entire faucet. toilet had a reddish brown der the rim of the bowl, and the smelled of urine. bathroom walls gouged near the r with missing paint. bathroom walls gouged near the r with missing paint. bathroom walls gouged near the r with missing paint. the second resident rooms 307 and 70 oriate housekeeping. The ESD al gouges identified in the rooms rere consistently large and obviou es measured 3-4"x 8-12."	t t 09 so 15, e s	DEFICIENC	ΥΥ)			
	IDENTIFICATION NUMBER:           00438           PLIER         STREE           735 TI           PERH           RY STATEMENT OF DEFICIENCIES           CIENCY MUST BE PRECEDED BY FULL           Y OR LSC IDENTIFYING INFORMATION)           om page 3           bathroom walls gouged with           near the bathroom door.           both corners in room had several both corners in room had several both corners in room had several both corners in gouged with           room and bathroom walls paint.           room and bathroom walls had           with gouges and missing paint           bathroom walls gouged with           In addition, the bathroom fauce           up over the entire faucet.           bathroom walls gouged with           In addition, the bathroom fauce           up over the entire faucet.           toilet had a reddish brown           der the rim of the bowl, and the           smelled of urine.           bathroom walls gouged near the           r with missing paint.           bathroom walls gouged near the           r with missing paint.           bathroom walls gouged near the           r with missing paint.           bathroom walls gouged near the           r with missing paint. <td>S       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE (A. BUILDING:</td> <td>S       (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING:         00438       B. WING         PLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         735 THIRD STREET SOUTHWEST PERHAM, MN 56573         PROVIDER/S PLAN OF CENCY MUST BE PRECIENCIES CIENCY MUST BE PRECIENCIES CIENCY MUST BE PRECIENCIES (EACH CORRECTIVE AC CROSS-REFERENCE)         OP REFIX CRACH CORRECTIVE AC CROSS-REFERENCE         OT A 21685         DEFICIENCIES DEATHORY MUST BE PRECIENCIES OF CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT TAG         OP REFIX CRACH CORRECTIVE AC CROSS-REFERENCED TO CROSS-REFERENCED TO DEFICIENT ON page 3         DEFICIENCIES DEATHORY WAILS gouged with near the bathroom door.         DEFICIENT TAG         DEFICIENT PREFIX         CONSERTECTION (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT DEFICIENT         DEFICIENT PREFIX         TAGE CONSERTED TO DEFICIENT DEFICIENT         DEFICIENT PREFIX         DEFICIENT PREFIX         DEFICIENT DEFICIENT         DEFICIENT PREFIX         DEFICIENT DEFICIENT         DEFICIENT DEFICIENT         DEFICIENT DEFICIENT         <td cols<="" td=""><td>S       (X1) PROVIDERSUPPLERICUAL       (X2) MULTIPLE CONSTRUCTION       (X3) DATL         00438       B. WING       05/         PLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       735 THIRD STREET SOUTHWEST         PERHAM, MN 56573       PERHAM, MN 56573         PY STATEMENT OF DEFICIENCES       ID       PROVIDER'S PLAN OF CORRECTION BUD BE         CROSS-REFERENCED OF THE APPROPRIATE       CROSS-REFERENCED OT THE APPROPRIATE       DEFICIENCY)         y OR LSC DENTIFYING INFORMATION       ID       PREFIX       CROSS-REFERENCED OT THE APPROPRIATE         VOR LSC DENTIFYING INFORMATION       ID       PREFIX       CROSS-REFERENCED OT THE APPROPRIATE         DEFICIENCY       TAG       PREFIX       CROSS-REFERENCED OT THE APPROPRIATE         DEFICIENCY       TAG       DEFICIENCY)       DEFICIENCY)         mp age 3       21685       DEFICIENCY)       DEFICIENCY)         mathroom walls gouged with       In addition, the bathroom faucet       DEFICIENCY)         &lt;</td></td></td>	S       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE (A. BUILDING:	S       (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING:         00438       B. WING         PLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         735 THIRD STREET SOUTHWEST PERHAM, MN 56573         PROVIDER/S PLAN OF CENCY MUST BE PRECIENCIES CIENCY MUST BE PRECIENCIES CIENCY MUST BE PRECIENCIES (EACH CORRECTIVE AC CROSS-REFERENCE)         OP REFIX CRACH CORRECTIVE AC CROSS-REFERENCE         OT A 21685         DEFICIENCIES DEATHORY MUST BE PRECIENCIES OF CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT TAG         OP REFIX CRACH CORRECTIVE AC CROSS-REFERENCED TO CROSS-REFERENCED TO DEFICIENT ON page 3         DEFICIENCIES DEATHORY WAILS gouged with near the bathroom door.         DEFICIENT TAG         DEFICIENT PREFIX         CONSERTECTION (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT DEFICIENT         DEFICIENT PREFIX         TAGE CONSERTED TO DEFICIENT DEFICIENT         DEFICIENT PREFIX         DEFICIENT PREFIX         DEFICIENT DEFICIENT         DEFICIENT PREFIX         DEFICIENT DEFICIENT         DEFICIENT DEFICIENT         DEFICIENT DEFICIENT <td cols<="" td=""><td>S       (X1) PROVIDERSUPPLERICUAL       (X2) MULTIPLE CONSTRUCTION       (X3) DATL         00438       B. WING       05/         PLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       735 THIRD STREET SOUTHWEST         PERHAM, MN 56573       PERHAM, MN 56573         PY STATEMENT OF DEFICIENCES       ID       PROVIDER'S PLAN OF CORRECTION BUD BE         CROSS-REFERENCED OF THE APPROPRIATE       CROSS-REFERENCED OT THE APPROPRIATE       DEFICIENCY)         y OR LSC DENTIFYING INFORMATION       ID       PREFIX       CROSS-REFERENCED OT THE APPROPRIATE         VOR LSC DENTIFYING INFORMATION       ID       PREFIX       CROSS-REFERENCED OT THE APPROPRIATE         DEFICIENCY       TAG       PREFIX       CROSS-REFERENCED OT THE APPROPRIATE         DEFICIENCY       TAG       DEFICIENCY)       DEFICIENCY)         mp age 3       21685       DEFICIENCY)       DEFICIENCY)         mathroom walls gouged with       In addition, the bathroom faucet       DEFICIENCY)         &lt;</td></td>	<td>S       (X1) PROVIDERSUPPLERICUAL       (X2) MULTIPLE CONSTRUCTION       (X3) DATL         00438       B. WING       05/         PLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       735 THIRD STREET SOUTHWEST         PERHAM, MN 56573       PERHAM, MN 56573         PY STATEMENT OF DEFICIENCES       ID       PROVIDER'S PLAN OF CORRECTION BUD BE         CROSS-REFERENCED OF THE APPROPRIATE       CROSS-REFERENCED OT THE APPROPRIATE       DEFICIENCY)         y OR LSC DENTIFYING INFORMATION       ID       PREFIX       CROSS-REFERENCED OT THE APPROPRIATE         VOR LSC DENTIFYING INFORMATION       ID       PREFIX       CROSS-REFERENCED OT THE APPROPRIATE         DEFICIENCY       TAG       PREFIX       CROSS-REFERENCED OT THE APPROPRIATE         DEFICIENCY       TAG       DEFICIENCY)       DEFICIENCY)         mp age 3       21685       DEFICIENCY)       DEFICIENCY)         mathroom walls gouged with       In addition, the bathroom faucet       DEFICIENCY)         &lt;</td>	S       (X1) PROVIDERSUPPLERICUAL       (X2) MULTIPLE CONSTRUCTION       (X3) DATL         00438       B. WING       05/         PLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       735 THIRD STREET SOUTHWEST         PERHAM, MN 56573       PERHAM, MN 56573         PY STATEMENT OF DEFICIENCES       ID       PROVIDER'S PLAN OF CORRECTION BUD BE         CROSS-REFERENCED OF THE APPROPRIATE       CROSS-REFERENCED OT THE APPROPRIATE       DEFICIENCY)         y OR LSC DENTIFYING INFORMATION       ID       PREFIX       CROSS-REFERENCED OT THE APPROPRIATE         VOR LSC DENTIFYING INFORMATION       ID       PREFIX       CROSS-REFERENCED OT THE APPROPRIATE         DEFICIENCY       TAG       PREFIX       CROSS-REFERENCED OT THE APPROPRIATE         DEFICIENCY       TAG       DEFICIENCY)       DEFICIENCY)         mp age 3       21685       DEFICIENCY)       DEFICIENCY)         mathroom walls gouged with       In addition, the bathroom faucet       DEFICIENCY)         <	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         00438				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/19/2016	
		B. WING				
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
PERHAN	I LIVING		RD STREET S( 1, MN 56573	OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21685	Continued From pa	ige 4	21685			
	No routine mainten maintenance and u were provided.	ance schedule for p keep for resident rooms				
	A facility maintenan was not provided.	nce policy was requested, but				
	The administrator of identified room con monitored on an or and resident satisfa assessment and as	THOD FOR CORRECTION: or designee could ensure all cerns are corrected and ngoing basis for good repair action. The quality ssurance committee could idits to ensure compliance.				
	TIME PERIOD FOR days.	R CORRECTION: Twenty (21	)			
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			6/23/16
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				
	by: Based on observati review the facility fa dining experience f	ent is not met as evidenced ion, interview and record ailed to provide a dignified or 1 of 2 residents (R77) eakfast in the Harvestglen		Corrected.		

STATEMEN	Dia Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00429	B. WING		05/	10/2016
		00438			05/	19/2016
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S <sup>-</sup> ID STREET SC			
PERHAN	I LIVING		I, MN 56573			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21805	Continued From pa	ige 5	21805			
	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.					
	9/16/15 identified R health problems, we expressing her idea confusion and slow indicated R77 requi she continued the t disorganized thoug complete a task she identified R77 had	essessment (CAA), dated 177 had dementia, mental eakness and difficulty as and wants because of her red thought process. The CAA ired supervision at meals so ask of eating, had ht processes and couldn't e had started. The CAA also dementia which interfered with attention span which included nking.				
	seated together at a the kitchenette area neighborhood. The the dining room, wit visible to R47 and F stood at the kitcher at the sink when die the dining room into	6 a.m. R47 and R77 were a dining room table in front of a of the Harvestglen kitchenette area was open to th the area both audible and R77. Nursing assistant(NA)-A nette counter, washing dishes etary aide (DA)-A walked from to the entryway of the tood in the entry way, less				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
00438		00438	B. WING		05/19/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
PERHAN	I LIVING		D STREET SC , MN 56573	OUTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21805	Continued From pa than 10 feet from R the table and stated she still eating?, ard proceeded to walk kitchenette and clos seated at the table with R47. On 5/19/16, at 11:0 residents in the dinic confirmed DA-A ma about R77. NA-A co same area as R77 loud comments, an been respectful tow felt DA-A had not tr manner when she r R77 out loud. On 5/19/16, at 11:1 been in the dining r DA-A stated R77 s eat and the time de on that day. DA-A co out to breakfast, an R77. DA-A confirmed dignified, and confir her make the negating	ge 6 77, who remained seated at d in a loud and harsh voice, "Is e you kidding me?" DA-A into the pantry of the sed the door. R77 remained of the kitchenette dining room 8 a.m. NA-A identified the ing room as R47 and R77, and ade the loud, harsh remarks onfirmed DA-A stood in the when DA-A made the harsh, d stated she felt DA-A had not vards R77. NA-A indicated she eated R77 in a dignified nade the comments about 1 a.m. DA-A stated R77 had oom for quite awhile today. ometimes took a long time to pended on how she was doing onfirmed R47 had just came d her comments identified ed her comments were not rmed R77 could have heard	21805			
	coordinator (RNCC little putsy lady." Sh to eat and sometim stated she felt staff negative comments dignity concern, and they could have heat	-A) stated R77 was a "cute le stated R77 took a long time es R77 couldn't focus. She speaking harsh, loud, s about a resident was a d if family had been present, ard the negative remarks also.				
innonata D	of conversations to	ected staff to keep those type themselves, or to share in a he stated she felt DA-A's				

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED		
0043		00438	B. WING	3. WING		19/2016		
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE				
PERHAM	I LIVING			OUTHWEST				
Year Control     Year Control       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES       ID     PROVIDER'S PLAN OF CORRECTION								
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE		
21805	Continued From pa	age 7	21805					
	remarks were undig	gnified.						
	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.							
	employees were hit training and were to regarding dignity a that time. She state for resident treatme practice. She state	p.m. DON stated when red the staff received dignity old of the facility expectations and how to treat residents at ed staff knew her expectations ent, and this was not common d she expected staff to treat yould like to be treated						
	by the DON, undate value of respect sta	facilities core values provided ed, identified under the core aff were to display a high eration for the dignity and ryone.						
	The administrator of regarding dignified assessment and as perform random au	THOD FOR CORRECTION: or designee could educate staff resident care. The quality ssurance committee could idits to ensure resident/staff propriate and facility is in						
	TIME PERIOD FOI	R CORRECTION: Fourteen						

STATEMENT OF DEFICIENCIES ( AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00438	B. WING		05/19/2016	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
PERHAN	I LIVING		RD STREET SO M, MN 56573	UTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21805	Continued From pa	age 8	21805			
	(14) days.					