



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 1, 2026

Administrator
Perham Living
735 THIRD STREET SOUTHWEST
PERHAM, MN 56573

RE: CCN:245486

Cycle Start Date: March 24, 2026

Dear Administrator:

On March 24, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
 - How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by June 24, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 24, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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:

<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112



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April 1, 2026

Administrator
Perham Living
735 THIRD STREET SOUTHWEST
PERHAM, MN 56573

Re: State Nursing Home Licensing Orders
Event ID: 1E3E21-H1

Dear Administrator:

The above facility survey was completed on March 24, 2026 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html.

The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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 feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, slightly slanted style.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245486		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - 1970 BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/24/2026	
NAME OF PROVIDER OR SUPPLIER Perham Living				STREET ADDRESS, CITY, STATE, ZIP CODE 735 THIRD STREET SOUTHWEST , PERHAM, Minnesota, 56573			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted on 03/24/2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Perham Living was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, The Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action		K0000			04/09/2026	

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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K0000	Continued from page 1 taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Perham Living NH was constructed at 3 different times. The original building, a 1-story building constructed in 1970 and was determined to be of Type II(000) construction. In 1979, a 1-story with a basement was added to the south west of the original building and was determined to be of Type II(222) construction. However, the building addition is not separated by a 2-hour fire barrier. These 2 buildings were completely renovated in 2006. In 2005 a 2-story building with basement was added to the south west of the 1970 building and was determined to be of Type II(222) construction. In 2016 the east end of the building was remodeled and included a new north entrance. This section is separated by a 2 hour fire barrier. The building is divided into 6 smoke compartments by 30- minute, 1- hour and 2- hour fire barriers. This was surveyed as one building. The building is fully fire sprinkler protected.. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 96 beds and had a census of 84 at time of the survey. The requirement at 42CFR, Subpart 416.44(b) is NOT MET as evidenced by:		K0000				
K0222 SS = D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one		K0222	Delayed egress removed from Transitions door noted in survey. All doors in building checked to assure labeled as delayed egress if applicable. Maintenance staff provided education regarding the need for signage required for any delayed egress doors. Audits conducted once weekly for 12 weeks to ensure corrective actions effective.		05/13/2026	

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K0222 SS = D	Continued from page 2 of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in		K0222	Continued from page 2 Facilities Director will monitor audit findings and ensure proper follow-up. Audit findings will be reviewed at QAPI. All corrections will be implemented by 5/13/26.			

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K0222 SS = D	Continued from page 3 buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain delayed egress doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2.4(2), and 7.2.1.6.1.1(3) and (4). This deficient finding could have an isolated impact on residents within the facility. Findings include: On 03/24/2026 at 9:26 AM, a delayed egress door was found in the Transitions wing that when tested opened in 30 seconds and did not have visible sign stating to it was a delayed egress door. The facility could not provide evidence showing that the door was allowed to have a 30-second delay before opening. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.		K0222				
K0271 SS = D	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain egress pathways per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.7, and 7.7.3.4. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 03/24/2026 at 10:04 AM, it was revealed by		K0271	A new gate was installed in stairwell 2890 to prevent occupants from traveling past the level of exit discharge. Building inspection completed to ensure all qualifying stairwells will meet this requirement. Maintenance staff provided with education regarding the requirement of approved means to prevent occupants from traveling past the level of exit discharge. Audits conducted once weekly for 12 weeks to ensure corrective actions effective. Facilities Director will monitor audit findings and ensure prompt follow-up. Audit findings will be reviewed at QAPI. All corrections will be implemented by 5/13/26.		05/13/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245486		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - 1970 BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/24/2026	
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K0271 SS = D	Continued from page 4 observation that in stairwell 2890, there was no gate of other approved means to prevent occupants from traveling past the level of exit discharge. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.		K0271				
K0351 SS = D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to install fire sprinkler systems per NFPA 101 (2012 edition), Life Safety Code, section 9.7.1.1, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, sections 6.2.7.1, 8.3.1.1, and 8.3.1.5.2. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 03/24/2026 at 9:14 AM, it was revealed by observation that a sprinkler head installed in a small closet in the front entry to the facility was missing an escutcheon plate, and it still had the plastic protective strap over the bulb.		K0351	An escutcheon plate was added and the plastic protective strap was removed from the identified sprinkler head. Building inspection conducted to ensure all sprinkler heads are installed properly. Maintenance staff provided with education regarding need to maintain properly installed sprinkler heads. Audits conducted once weekly for 12 weeks to ensure corrective actions effective. Facilities Director will monitor audit findings and ensure prompt follow-up. Audit findings will be reviewed at QAPI. All corrections will be implemented by 5/13/26.		05/13/2026	

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K0351 SS = D	Continued from page 5	K0351		
K0761 SS = F Bldg. 01	An interview with the Maintenance Director and the Administrator verified this deficient finding at the time of discovery. Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain fire and smoke dampers per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.6, and 4.6.12 and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, sections 19.4.7, 5.2.14.1, and 13.4. These deficient findings could have a widespread impact on residents within the facility. Findings include: On 03/24/2026 at 9:10 AM, it was revealed by observation that there were blue IT wires running through the fire and smoke dampers which could prevent the dampers from closing when activated, above the doors by the business offices separating the nursing home from the assisted living facility. On 03/24/2026 at 9:52 AM, it was revealed by observation that the rolling fire doors in the kitchen area of Pine Harbor and Forest Glen had markings on them that they had not been tested since June of 2020. Staff could not confirm that the doors closed when the fire alarm activated. On 03/24/2026 at 10:12 AM, it was revealed by observation that the rolling fire doors in the kitchen area of Burlington and Timber Grove had markings on	K0761	IT wires removed from going through the fire and smoke dampers. Building inspection conducted to ensure no additional wires or other items are going through the fire and smoke dampers throughout the building. Maintenance and IT staff provided with education regarding need to maintain clearance through fire and smoke dampers. Audits conducted once weekly for 12 weeks to ensure corrective actions effective. Facilities Director will monitor audit findings and ensure prompt follow-up. Audit findings will be reviewed at QAPI. Rolling fire doors located in affected households (Pine Harbor, Harvest Glen, Burlington and Timber Grove kitchen areas) were inspected by American DoorWorks on 4/7/26 and passed all testing. These doors will be inspected annually moving forward. Building inspection conducted to ensure all rolling doors have been inspected. Maintenance staff provided with education regarding need to maintain annual inspection of these fire doors. Audits conducted once weekly for 12 weeks to ensure corrective actions effective. Facilities Director will monitor audit findings and ensure prompt follow-up. Audit findings will be reviewed at QAPI. Same correction as above. This fire door was adjusted so it closes properly. Building inspection was conducted to verify that all doors close and latch properly; no additional issues were identified. Maintenance staff provided with education regarding the need for proper functioning fire doors. Audits conducted once weekly for 12 weeks to ensure corrective actions effective. Facilities Director will monitor audit findings and ensure prompt follow-up. Audit findings will be reviewed at QAPI. All corrections will be implemented by 5/13/26.	05/13/2026

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245486		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - 1970 BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/24/2026	
NAME OF PROVIDER OR SUPPLIER Perham Living				STREET ADDRESS, CITY, STATE, ZIP CODE 735 THIRD STREET SOUTHWEST , PERHAM, Minnesota, 56573			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0761 SS = F Bldg. 01	Continued from page 6 them that they had not been tested since June of 2020. Staff could not confirm that the doors closed when the fire alarm activated. On 03/24/2026 at 10:42 AM, it was revealed by observation that the fire door in the basement separating the nursing home and the assisted living facility did not close and latch properly when released from the magnetic hold-open device.An interview with the Maintenance Director and the Administrator verified these deficient findings at the time of discovery.			K0761			