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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 2YTB
Facility ID: 00355

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245535**

2. STATE VENDOR OR MEDICAID NO. (L2) **833840000**

3. NAME AND ADDRESS OF FACILITY
(L3) **JOURDAIN PERPICH EXT CARE FAC**
(L4) **24856 HOSPITAL DRIVE**
(L5) **REDLAKE, MN** (L6) **56671**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **05/16/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **47** (L18)

13.Total Certified Beds **47** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	47			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): A revisit was conducted to verify correction of the standard survey and Federal Monitoring Survey. Based on the revisits, the facility achieved compliance resulting in remedies being rescinded

17. SURVEYOR SIGNATURE Date :
Michelle Koch, HFE NEII 09/08/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/11/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **12/30/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **09201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **05/09/2017** (L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

CMS Certification Number (CCN): 245535

September 8, 2017

Mr. Nick Berg, Administrator
Jourdain Perpich Extended Care Facility
24856 Hospital Drive
Redlake, MN 56671

Dear Mr. Berg:

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 8, 2017 the above facility is certified for:

47 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 47 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 letter.

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
Phone: (651) 201-4118 Fax: (651) 215-9697

Electronically delivered
September 8, 2017

Mr. Nick Berg, Administrator
Jourdain Perpich Extended Care Facility
24856 Hospital Drive
Redlake, MN 56671

RE: Project Number S5535029, F5535027

Dear Mr. Berg:

On March 27, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 9, 2017. 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 March 29, 2017, a surveyor representing the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The FMS 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 April 7, 2017, CMS forwarded the results of the FMS to you and informed you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed the following enforcement remedy:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective June 9, 2017. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of April 7, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 9, 2017.

On May 16, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 21, 2017 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 March 9, 2017 and the FMS completed on March 29, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 8, 2017. Based on our PCR, we have determined that your

facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 9, 2017 and the FMS completed on March 29, 2017, effective June 8, 2017.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in their letter of April 7, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective June 9, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective June 9, 2017 is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective June 9, 2017 is to be rescinded.

In their letter of April 7, 2017, CMS advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 9, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on June 8, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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 letter.

Sincerely,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 245535

April 7, 2017
By Certified Mail and EPOC

Mr. Larry Passel, Administrator
Jourdain Perpich Extended Care Facility
24856 Hospital Drive
Redlake, MN 56671

Dear Mr. Passel:

SUBJECT: FEDERAL MONITORING SURVEY RESULTS AND NOTICE OF IMPOSITION OF CIVIL MONEY PENALTY
Cycle Start Date: March 9, 2017

STATE SURVEY RESULTS
On March 7, 2017, a Life Safety Code (LSC) survey and on March 9, 2017, a health survey were completed at Jourdain Perpich Extended Care Facility by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. These surveys found that your facility was not in substantial compliance with the most serious deficiencies at Scope and Severity (S/S) level F, cited as follows:

- K712 -- S/S: F -- NFPA 101 -- Fire Drills
- F441 -- S/S: F -- 483.80(a)(1)(2)(4)(e)(f) -- Infection Control, Prevent Spread, Linens

The MDH advised you of the deficiencies that led to this determination and provided you with a copy of the survey report (CMS-2567).

FEDERAL MONITORING SURVEY
On March 29, 2017, a surveyor representing this office of the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continues to not be in substantial compliance. The FMS found additional deficiencies, with the most serious cited as follows:

- K281 -- S/S: F -- NFPA 101 -- Illumination of Means of Egress
- K342 -- S/S: F -- NFPA 101 -- Fire Alarm System - Initiation
- K345 -- S/S: F -- NFPA 101 -- Fire Alarm System - Testing and Maintenance
- K351 -- S/S: F -- NFPA 101 -- Sprinkler System - Installation
- K353 -- S/S: F -- NFPA 101 -- Sprinkler System - Maintenance and Testing

- K372 -- S/S: F -- NFPA 101 -- Subdivision of Building Spaces - Smoke Barrie
- K711 -- S/S: F -- NFPA 101 -- Evacuation and Relocation Plan
- K712 -- S/S: F -- NFPA 101 -- Fire Drills

The findings from the FMS will be posted on the ePOC system.

ELECTRONIC PLAN OF CORRECTION (ePOC)
Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the enclosed deficiencies cited at the FMS. 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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation.

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

INFORMAL DISPUTE RESOLUTION
The MDH offered you an opportunity for Informal Dispute Resolution (IDR) following its survey visits. A request for IDR will not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

CMS has established an IDR process to give providers one opportunity to informally refute deficiencies cited at a Federal survey, in accordance with the regulation at 42 CFR §488.331. To use this process, you must send your written request, identifying the specific deficiencies you are disputing to Stephen Pelinski at the Chicago address shown above. The request must set forth in detail your reasons for disputing each deficiency and include copies of all relevant documents supporting your position. A request for IDR will not delay the effective date of any enforcement action, nor can you use it to challenge any other aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care
- Remedies imposed
- Alleged failure of the surveyor to comply with a requirement of the survey process
- Alleged inconsistency of the surveyor in citing deficiencies among facilities

- Alleged inadequacy or inaccuracy of the IDR process

You must submit your request for IDR within the same ten (10) calendar day timeframe for submitting your ePOC. You must provide an acceptable ePOC for all cited deficiencies, including those that you dispute. We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

LIFE SAFETY CODE (LSC) WAIVERS
If you request an annual waiver for a LSC deficiency cited during the FMS, the request must indicate why correcting would impose an unreasonable hardship on the facility; if high cost is the hardship, you must include recent, bona fide cost estimates. In addition, the request must indicate how continued non-correction of the deficiency will not pose a risk to resident safety, based on additional compensating features or other reasons.

Each cited deficiency (other than those which receive annual waivers) must be corrected within a reasonable timeframe. If a reasonable correction date falls beyond your enforcement cycle's three month date, you may request a temporary waiver to allow correction by the reasonable date, and without the noncompliance leading to the imposition of remedies. Include a request for a temporary waiver as part of your POC, indicating the basis for the length of correction time needed, and include a timetable for correction. A temporary waiver may be granted if the POC date extends beyond your enforcement cycle's three month date, and if the correction timeframe is reasonable, in CMS' judgment. Your enforcement cycle's three month date is June 9, 2017.

SUMMARY OF ENFORCEMENT REMEDIES
As a result of the survey findings we are imposing the following remedy:

- Mandatory denial of payment for new admissions effective June 9, 2017

The authority for the imposition of remedies is contained in subsections 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR § 488 Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

DENIAL OF PAYMENT FOR NEW ADMISSIONS
Mandatory denial of payment for all new Medicare admissions is imposed effective June 9, 2017, if your facility does not achieve compliance within the required three months. This action is mandated by the Act at §§ 1819(h)(2)(D) and 1919 (h)(2)(C) and Federal regulations at 42 CFR § 488.417(b). We will notify your Medicare Administrative Contractor that the denial of payment for all new Medicare admissions is effective on June 9, 2017. We are further notifying the State Medicaid agency that they must also deny payment for all new Medicaid admissions effective June 9, 2017.

You should notify all Medicare and Medicaid residents admitted on or after this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in managed care

plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payment for new admissions.

TERMINATION PROVISION
If your facility has not attained substantial compliance by September 9, 2017, your Medicare and Medicaid participation will be terminated effective with that date. This action is mandated by the Act at §§ 1819(h) and 1919(h) and Federal regulations at 42 CFR §488.456 and §489.53.

We are required to provide the general public with notice of an impending termination and will publish a notice in a local newspaper prior to the effective date of termination. If termination goes into effect, you may take steps to come into compliance with the Federal requirements for long term care facilities and reapply to establish your facility's eligibility to participate as a provider of services under Title XVIII of the Act. Should you seek re-entry into the Medicare program, the Federal regulation at 42 CFR § 489.57 will apply.

NURSE AIDE TRAINING PROHIBITION
Please note that Federal law, as specified in the Act at §1819(f)(2)(B) and §1919(f)(2)(B), prohibits approval of Nurse Aide Training and Competency Evaluation Programs (NATCEP) and Nurse Aide Competency Evaluation Programs offered by, or in, a facility which, within the previous two years, has operated under a §1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 9, 2017, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Jourdain Perpich Ext Care Facility will be prohibited from offering or conducting a NATCEP for two years from June 9, 2017. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

APPEAL RIGHTS
This formal notice imposed the following remedy:

- Mandatory denial of payment for new admissions effective June 9, 2017

If you disagree with the findings of noncompliance which resulted in this imposition, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR § 498.

You are required to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/. To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

- Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking **Civil Remedies Division** on the File New Appeal screen.
- Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked **E-Filing Instructions** after logging-in to DAB E-File.

For questions regarding the E-Filing system, please contact E-File System Support at **OSDABImmediateOffice@hhs.gov**.

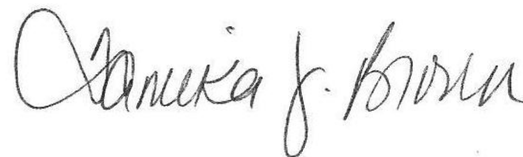
Please note that **all** hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Nancy K. Rubenstein, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

A request for a hearing must be filed no later than 60 days from the date of receipt of this notice. It is important that you send a copy of your request to our Chicago office to the attention of Tamika J. Brown.

CONTACT INFORMATION
If you have any questions, please contact Tamika J. Brown, Principal Program Representative at (312) 353-1502. Information may also be faxed to (443) 380-6614.

Sincerely,



Tamika J. Brown
Acting Branch Manager
Long Term Care Certification
& Enforcement Branch

cc: Minnesota Department of Health
Minnesota Department of Human Services
Office of Ombudsman for Older Minnesotans
Stratis Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING **01 - NURSING HOME** B. WING ______	03/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	**24856 HOSPITAL DRIVE** **REDLAKE, MN 56671**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 3/29/17 following a Minnesota Department of Health Services Survey on 3/7/17. At this Comparative Federal Monitoring Survey Jourdain Perpich Extended Care Facility was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.90(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101 - 2012 edition. Jourdain Perpich Extended Care Facility is a one story building of Type II (000) construction that was built in 1989. The building is fully sprinklered and there is supervised smoke detection located in the corridors and spaces open to the corridors. The facility has 47 certified beds. All 47 beds are dually certified for Medicare and Medicaid. At the time of the survey, the census was 26. The requirement at 42 CFR, subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 131 SS=E	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: * They are not intended to serve four or more inpatients. * They are separated from areas of health care occupancies by construction having a minimum 2-hour fire resistance rating in accordance with Chapter 8.	K 131		6/8/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/20/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING **01 - NURSING HOME** B. WING ______	**03/29/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	**24856 HOSPITAL DRIVE** **REDLAKE, MN 56671**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 131	Continued From page 1 * The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to maintain the two-hour rated, building separations between the skilled nursing building and the assisted living building in accordance with the requirements of NFPA 101 - 2012 edition, Sections 19.1.3, 19.1.3.3, 8.3, 8.3.1, 8.3.3, 8.3.5, 8.3.5.7, 9.2.1 and NFPA 90A - 2012 edition. This deficient practice could affect approximately 18 of the 26 residents. Findings include: 1. On 3/29/17 at 12:56pm, observation revealed that above the ceiling at the 2-hour rated fire wall between the hospital and the skilled nursing unit the top 1/2" of the wall was open and not properly firestopped. 2. On 3/29/17 at 1:03pm, observation revealed that above the ceiling at the 2-hour rated fire wall between the dining room and the kitchen there was a 10" by 30" section of the wall where one side of the concrete block wall was missing where a pipe projected down from above. This section of wall did not have a 2-hour rating. 3. On 3/29/17 at 1:04pm, observation revealed that the two doors between the dining room and the kitchen and the door between the dining room	K 131	The facility will ensure that two-hour fire rating building separations are maintained. Necessary repairs and modifications will be completed. 1. Enclose and properly firestop above the ceiling at the two-hour rated fire wall between the hospital and skilled nursing unit. 2. Enclose and properly firestop above the ceiling at the two-hour rated fire wall between the dining room and the kitchen. 3. Replace the two doors between the dining room and the kitchen and replace the door between the dining room and the corridor. The replacement doors will have a minimum of 90-minute fire rating. 4. Enclose and properly firestop the 3" gap above the duct and pipe penetration in the wall by room 8. The facility will conduct an audit of all fire door to ensure that they are marked properly with adequate fire rating. The facility will also audit each room and corridor walls to ensure that all penetrations are properly fire stopped and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING **01 - NURSING HOME** B. WING ______	**03/29/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	**24856 HOSPITAL DRIVE** **REDLAKE, MN 56671**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 131	Continued From page 2 and the corridor were located in a 2-hour fire wall. The doors had a label stating that they were "fire doors" but they did not indicate what fire resistance rating the doors had. The facility had no documentation indicating that the fire doors were a minimum of 90-minute rated. 4. On 3/29/17 at 1:15pm, observation revealed that at the 2-hour rated wall by room 8 there was a 3" gap in the wall above the duct and a pipe penetration that were not properly firestopped. These findings were confirmed by the Tribal Sanitarian at the times of discovery.	K 131	that no gaps are present. The Administrator is responsible for completion and correction shall be completed by June 8, 2017.	
K 281 SS=F	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This STANDARD is not met as evidenced by: Based on interview, the facility failed to provide a reliable source of illumination at exit discharges in accordance with the requirements of NFPA 101 - 2012 edition, Sections 19.2.8, 7.8, 7.8.1 7.8.2 and 7.8.2.1. This deficient practice could affect all 26 residents. Findings include: On 3/29/17 at 1:18pm, an interview with the Tribal Sanitarian revealed that none of the lights at the exit discharges were on emergency power.	K 281	The facility will ensure that electrical upgrades will be made to provide emergency power to all exit discharges. The Administrator is responsible for completion.	6/8/17
K 342 SS=F	NFPA 101 Fire Alarm System - Initiation	K 342		6/8/17

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	245535	A. BUILDING **01 - NURSING HOME** B. WING ____	**03/29/2017**

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K 342	Continued From page 3 Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to install the fire alarm system in accordance with the requirements of NFPA 101 - 2012 edition, sections 19.3.4, 9.6 and NFPA 72 - 2010 edition, sections 10.14.3 and 10.14.3.1. This deficient practice had the potential to affect all 26 residents. Findings include: On 3/29/17 at 1:27pm, observation revealed that in the employee break room the smoke detector was located within the air flow of the adjacent air supply outlet. This finding was confirmed by the Tribal Sanitarian at the time of discovery.	K 342	The facility will obtain the services of a licensed fire protection contractor to make necessary changes such that the smoke detector is not located within the airflow of adjacent air supply outlet. The contractor will review all smoke detectors to ensure that all smoke detectors in the facility are not within the airflow of adjacent air supply outlets. The Administrator is responsible for completion.	
K 345 SS=F	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying	K 345		5/8/17

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K 345	Continued From page 4 with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to test the fire alarm system in accordance with the requirements of NFPA 101 - 2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.4.1.2, 14.4.2 and 14.4.5. This deficient practice could affect all 26 residents. Findings include: 1. On 3/29/17 at 10:32am, review of the document titled "Northern Fire Protection Fire Alarm Inspection and Testing Form" dated 11/29/16 revealed that the inventory list of devices was not accurate. The inventory list indicated that there were 25 smoke detectors in the facility but an individual list of devices that were tested showed that 29 smoke detectors were tested. 2. On 3/29/17 at 10:35am, review of the document titled "Sensitivity Report for Red Lake Hosp & Jordain-Perpich ECF-2014" dated 2/27/14 revealed that the smoke detectors had not been tested for sensitivity within the last two years. These findings were confirmed by the Tribal	K 345	The facility will obtain the services of a licensed fire protection contractor to complete an accurate and complete inventory list of smoke detectors in the facility. The contractor will also complete smoke detector sensitivity testing. The Administrator is responsible for ensuring completion.	

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K 345	Continued From page 5 Sanitarian and the Facility Manager of Red Lake Hospital at the times of discovery.	K 345		
K 351 SS=F	NFPA 101 Sprinkler System - Installation 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 interview, the facility failed to install the sprinkler system in accordance with the requirements of NFPA 101 - 2012 edition, Sections 19.3.5 and 9.7: NFPA 13 - 2010 edition, Sections 8.1 and 8.5.5.3.1. This deficient practice could affect all 26 residents. Findings include: 1. On 3/29/17 at 11:45am, observation revealed that in the mechanical room by room 194 there was no sprinkler located below the 8' wide duct. 2. On 3/29/17 at 1:32pm, observation revealed	K 351	The facility will obtain the services of a licensed sprinkler contractor to install necessary sprinkler systems in the mechanical room by room 194, mechanical room by 139, server room and mechanical room by room 163. The contractor will also review the entire sprinkler system to ensure compliance with all relevant requirements. The Administrator is responsible for completion.	6/8/17

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K 351	Continued From page 6 that the mechanical room by room 139 was not sprinklered. 3. On 3/29/17 at 1:38pm, observation revealed that the back room of the server room was not sprinklered. 4. On 3/29/17 at 1:39pm, observation revealed that the mechanical room by room 163 was not sprinklered. These findings were confirmed by the Tribal Sanitarian at the time of discovery.	K 351		
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _______________ b) Who provided system test ____________________ c) Water system supply source __________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain its automatic sprinkler system in	K 353	The facility will obtain the services of a licensed sprinkler contractor to perform	6/8/17

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K 353	Continued From page 7 accordance with NFPA 101 - 2012 edition, Sections 19.3.5, 9.7 and NFPA 25 - 2010 edition, Sections 5.1.1.2, 5.2.1, 5.2.1.1 and 5.4.1.4.2. This deficient practice had the potential to affect all 26 residents. Findings include: 1. On 3/29/17 at 10:45am, review of the documents titled "Brothers Fire Report of Inspection" dated 2/21/17 and 12/8/16 revealed that there was no annual inspection of the sprinkler system. 2. On 3/29/17 at 10:46am, review of the documents titled "Brothers Fire Report of Inspection" dated 2/21/17 and 12/8/16 revealed that there were only two quarterly waterflow tests conducted in the last 12 months. These findings were confirmed by the Tribal Sanitarian and the Facility Manager of Red Lake Hospital at the time of discovery.	K 353	annual inspection of the sprinkler system and to perform quarterly waterflow tests. The administrator will conduct quarterly audits to ensure that waterflow tests and annual inspections are performed timely. The Administrator is responsible for completion.	
K 363 SS=E	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and	K 363		5/8/17

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K 363	Continued From page 8 floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to provide corridor doors in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.6.3 and 19.3.6.3.1. This deficient practice could affect approximately 10 of the 26 residents. Findings include: On 3/29/17 at 11:53am, observation revealed that there were four 3/16" size holes in the corridor door to room 165. This finding was confirmed by the Tribal Sanitarian at the time of discovery.	K 363	The facility will replace door latch with a latch that utilizes and covers the 4 holes on the door for room 165. An audit of all doors will be completed to ensure that no other doors have holes or defects that compromise fire rating or integrity. The Administrator is responsible for completion.	
K 372	NFPA 101 Subdivision of Building Spaces -	K 372		5/8/17

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K 372 SS=F	Continued From page 9 Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barrier walls in accordance with the requirements of NFPA 101 - 2012 edition, Sections 19.3.7, 19.3.7.1, 19.3.7.3, 8.5, 8.5.2 and 8.5.6. This deficient practice could affect all 26 residents. Findings include: 1. On 3/29/17 at 11:32am, observation revealed that above the ceiling at the smoke barrier by room 123 the top 1/2" of the wall was open and there were penetrations of three insulated pipes that were not properly firestopped. 2. On 3/29/17 at 11:35am, observation revealed that above the ceiling at the smoke barrier by the beauty shop there were penetrations of two conduits that were not properly firestopped. 3. On 3/29/17 at 11:40am, observation revealed that above the ceiling at the smoke barrier by	K 372	The facility will maintain smoke barrier walls. The facility will make the following repairs/modifications: 1. Enclose and properly firestop above the ceiling at the smoke barrier by room 123 such that the ½" gap is eliminated and that the three pipe penetrations are sealed. 2. Properly firestop above the ceiling at the smoke barrier by the beauty shop such that the pipe penetrations are sealed. 3. Enclose and properly firestop above the ceiling at the smoke barrier by room 194 such that the ½" gap at the top of the wall is eliminated. 4. Properly firestop above the ceiling at the smoke barrier by room 194 such that	

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K 372	Continued From page 10 room 194 there was a 1/2" gap at the top of the wall that was not properly firestopped. 4. On 3/29/17 at 11:46am, observation revealed that above the ceiling at the smoke barrier in room 194 there were penetrations of a conduit and a pipe that were not properly firestopped. 5. On 3/29/17 at 11:51am, observation revealed that above the ceiling at the smoke barrier in room 148 there were penetrations of a conduit and a cable that were not properly firestopped. 6. On 3/19/17 at 11:56am, observation revealed that above the ceiling at the smoke barrier in room 165 there was a penetration of a pipe that was not properly firestopped. These findings were confirmed by the Tribal Sanitarian at the times of discovery.	K 372	the conduit and pipe penetrations are sealed. 5. Properly firestop above the ceiling at the smoke barrier by room 148 such that the conduit and cable penetrations are sealed. 6. Properly firestop above the ceiling at the smoke barrier by room 165 such that the pipe penetration is sealed. The Administrator will conduct quarterly audits of smoke barriers to ensure they are not compromised by non-firestopped penetrations from any additional equipment installed. The Administrator is responsible for completion.	
K 711 SS=F	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This STANDARD is not met as evidenced by: Based on record review and interview the facility	K 711	The facility will revised the Fire Safety	5/19/17

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K 711	Continued From page 11 failed to have a written fire safety plan that addressed all of the items required by NFPA 101 - 2012 edition, Section 19.7.2.2. This deficient practice could affect all of the 26 residents. Findings include: On 3/29/17 at 10:16am, review of the undated document titled "Jourdain Perpich Extended Care Center, Policy and Procedure: Fire Safety and Evacuation Plan Summary" dated "Revised August 2007" revealed that the facility's written fire safety plan did not address the transmission of the fire alarm to the fire department. This finding was confirmed by the Tribal Sanitarian and the Facility Manager of Red Lake Hospital at the time of discovery.	K 711	and Evacuation Plan policy and procedure to specify that the fire alarm system automatically notifies the local fire department. Staff will verify at the time of the alarm or drill that the local fire department has received notification of the alarm. Fire Drill evaluation records have been modified to address this as well. A staff education event will be held on 4/27 to update the staff on the fire plan and changes to the plan. Fire Drill evaluation records have been modified to address this as well. Administrator will audit monthly fire drill records to ensure that the procedure is being followed. Administrator is responsible for completion.	
K 712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to conduct fire drills in accordance with, the	K 712	The facility will complete fire drills at unexpected times and under varying	4/28/17

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K 712	Continued From page 12 requirements of NFPA 101 - 2012 edition, Sections 4.7.1, 4.7.2, 4.7.6, 19.7.1, 19.7.1.4 and 19.7.1.6. This deficient practice had the potential to affect all 26 residents. Findings include: 1. On 3/29/17 at 10:16am, review of the documents titled "Jourdain/Perpich Extended Care Center Fire Drill Report" for the last 12 months revealed that there were no fire drills conducted on the first or third shifts during the first quarters of 2016 or 2017 and there was no fire drill conducted on the third shift during the fourth quarter of 2016. 2. On 3/29/17 at 10:17am, review of the documents titled "Jourdain/Perpich Extended Care Center Fire Drill Report" for the last 12 months revealed fire drills were not conducted at varied times. Two of the two drills conducted on the third shift were conducted between 4:13am and 4:50am. Three of the six fire drills on the second shift were conducted between 3:15pm and 3:30pm and the other three drills were conducted between 4:10pm and 4:30pm. These findings were confirmed by the Tribal Sanitarian and the Facility Manager of Red Lake Hospital at the time of discovery.	K 712	conditions, at least quarterly on each shift. The person responsible for conducting fire drills has been educated to conduct one drill per month and to rotate shifts monthly such that each shift has one fire drill per quarter. The time of the drill for each shift is to vary by at least 3 hours. Administrator will audit monthly fire drill records to ensure that the procedure is being followed. Administrator is responsible for completion.	
K 741 SS=E	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored	K 741		4/6/17

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K 741	Continued From page 13 and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide and maintain a smoking area that addressed all the items required in NFPA 101 - 2012 edition, Section 19.7.4. This deficient practice had the potential to affect approximately 10 of the 26 residents. Findings include: On 3/29/17 at 1:45pm, observation revealed that at the employee smoking area cigarette butts and trash were mixed in the plastic trash can. There was an approximate 4" hole burnt through the side of the trash can. There was not an approved ash tray and there was no self-closing covered metal container for the disposal of cigarette butts and ashes.	K 741	The facility has moved the employee smoking area away from the facility approximately 150 feet and has provided a metal container with self-closing cover at this site. Sign has been placed at the former smoking area that reads NO SMOKING with symbol for no smoking. All staff members were educated on the new smoking area and procedure for disposing of butts on April 5th and April 6th. Administrator will conduct weekly audits to ensure staff are smoking in the approved area. Administrator is responsible for completion.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING **01 - NURSING HOME** B. WING ______	**03/29/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	**24856 HOSPITAL DRIVE** **REDLAKE, MN 56671**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 741	Continued From page 14 This finding was confirmed by the Tribal Sanitarian at the time of discovery.	K 741		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 2YTB
Facility ID: 00355

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245535**
2. STATE VENDOR OR MEDICAID NO. (L2) **833840000**

3. NAME AND ADDRESS OF FACILITY
(L3) **JOURDAIN PERPICH EXT CARE FAC**
(L4) **24856 HOSPITAL DRIVE**
(L5) **REDLAKE, MN** (L6) **56671**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **03/09/2017** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 04 SNF 08 OPT/SP 12 RHC 16 HOSPICE

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12. Total Facility Beds **47** (L18)
13. Total Certified Beds **47** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
___ 1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: B* (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	47			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

Mandatory DPNA is effective June 9, 2017.

17. SURVEYOR SIGNATURE Date :
Michelle Koch, HFE NE II 04/07/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 05/09/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
___ 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **12/30/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **09201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 27, 2017

Mr. Nick Berg, Administrator
Jourdain Perpich Extended Care Facility
24856 Hospital Drive
Red Lake, Minnesota 56671

RE: Project Number S5535029

Dear Mr. Berg:

On March 9, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

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

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Brenda.fischer@state.mn.us
Phone: (320) 223-7338   Fax: (320) 223-7348

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 April 18, 2017, 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 April 18, 2017 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 June 9, 2017 (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 September 9, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING ______ B. WING ______	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	**24856 HOSPITAL DRIVE REDLAKE, MN 56671**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 3/6/17 to 3/9/17, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Jourdain Perpich Extended Care Center was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=C	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing	F 156		4/18/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/05/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 1 (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING ______ B. WING ______	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

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F 156	Continued From page 2	F 156		

information regarding returning to the community.

(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)
[§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]

(iii) Information regarding Medicare and Medicaid eligibility and coverage;
[§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;
[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]

(v) Contact information for the Medicaid Fraud Control Unit; and
[§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]

(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 3	F 156		

misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:

(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and

(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.

(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 4	F 156		

(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident’s stay.

(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;

(g)(17) The facility must--

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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JOURDAIN PERPICH EXT CARE FAC	**24856 HOSPITAL DRIVE** **REDLAKE, MN 56671**

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F 156	Continued From page 5 this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident’s stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility’s per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility’s per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident’s date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the	F 156		

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F 156	Continued From page 6 facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide residents/family's with an updated written copy of Federal bill of rights, and have a process to review these rights with residents/family's. This had the potential to affect all 26 residents residing in the facility. Findings include: During interview on 3/7/17, at 1:37 p.m. R16 stated residents had not been updated on the new bill of rights, to his knowledge. Review of the resident council meeting minutes from November 2016, to February 2017, did not identify resident rights were reviewed with residents, or that the rights had been updated. During interview on 3/9/17, at 1:57 p.m. the social services designee (SSD)-A stated she had not incorporated discussing resident rights during the monthly resident council meetings. They had not yet developed a process she was aware of for the facility to review resident rights and to discuss these right with residents and family's. During interview on 3/9/17, at 2:23 p.m. the director of nursing (DON) stated the facility had just received copies of the new updated federal bill of rights to give the residents on 3/6/17. The facility had not reviewed or given these copies to any residents or family's to date. A policy on resident rights was requested and not	F 156	F156 All residents will be updated on the latest version of the combined federal and state bill of rights dated 11/28/2016. This will be accomplished by reviewing individually and obtaining a signed acknowledgment from each resident and/or family member. A review of the combined federal and state bill of rights will be discussed at the Resident Council meeting on April 13, 2017. Upon admission all residents and/or responsible parties will receive a copy of the combined updated federal and state bill of rights. The Administrator will audit monthly for 4 months to verify that each new admission has been given the combined federal and state bill of rights and that signed acknowledgments have been obtained. The results of the audit will be reviewed at monthly QAA committee meetings. The Social Services Designee is responsible for correction and ongoing compliance.	

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F 156	Continued From page 7 received.	F 156		
F 248 SS=D	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document the facility failed to ensure a comprehensive activity assessment was developed to meet individual needs for 2 of 3 residents (R23, R9) reviewed for activities. Findings include: R23's quarterly Minimum Data Set (MDS) on 1/31/2017, identified a diagnosis of dementia, had severe cognitive impairment, and needed total staff assistance for activities of daily living. During interview with R23 on 3/06/2017 at 3:15 pm stated, she periodically gazes at the television, looks outside and listens for the hospital helicopter come in for a landing, (helicopter pad right outside R23's window). She stated that "every day" she had periods of boredom.	F 248	F248 Comprehensive activity assessments have been completed to meet the individual needs of R9 and R23 that include information regarding the resident’s past and current interests. Activity care plans for R9 and R23 have been updated to include individual preferences and give guidance to activity staff in providing meaningful 1:1 visits. Resident Activity Preference Assessment has been modified to improve the gathering of individual preferences and help to develop an individualized activity plan of care. Activity assessments and care plans will be competed for all residents during the next 2 months at a rate of 4 residents per	4/18/17

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During interview on 3/7/17 in the afternoon NA-B stated (R23) likes to play bingo. Staff will ask her to go but it depends on how she feels. She mostly stays in her room but does come out when she wants to, and they do see activity staff in her room, but they were unsure of what they do.

During observation on 3/8/17 at 11:41 R23 was in her room in bed with the television on. At 12:50 R23 placed her call light for a drink of water, and at 1:12 p.m. R23 remained in bed in her room.

In an interview on 3/8/17 at 1:12 NA-D, stated R23 frequently turns her call light on 20 times a shift for either a drink of water, to be repositioned or to do things in her room.

During observation on 3/9/17 at 8:27 a.m. R23 was in bed in her room, asleep.

Review of R23's Activity Interview of Daily and Activity Preferences sheet dated, 7/20/16 identified it was very important for R23 to have books and newspapers to read, music, to be around animals, do favorite activities, get fresh air and participate in religious services. There was no indication of what type of music, books, newspaper she preferred, what her favorite actives were, or what religious service she preferred.

R23's care plan last revised on 2/15/17 identified resident prefers not to participate in group activities, enjoys playing bingo occasionally and going shopping. The goal was the resident would express satisfaction with the type of activities and level of involvement. Staff were directed to encourage the resident to participate by inviting

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week beginning 4/10/2017. Dependent resident's requiring 1:1 visits will be completed first. Activity staff has been educated on 4/5-6/2017 regarding providing meaningful and resident specific 1:1 activities. The Activity Director has been provided with education and materials regarding completion of assessments and care plans.

Audits of care plans and activity documentation including 1:1's will be completed weekly for 2 months and then monthly for 4 months for R9 and R23 as well as all residents requiring 1:1 activities. The results of the audit will be reviewed at monthly QAA committee meetings.

Activity Director will be responsible. Corrective action will be completed by April 18, 2017.

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resident to group activities, modify daily schedule, treatment plan as needed to accommodate activity participation as requested by the resident. Resident needs 1:1 time with activity staff three times a week. Although the care plan identified R23's preferred not to participate in group activities, the care plan directed staff to invite and encourage R23 to attend group activities.

Review of the February 2017 JPECC (Jourdain Perpich Extended Care Center) Activity Flow Sheet identified R23 had seven 1:1 visits, and not twelve 1:1 as identified by the care plan. Review of the Activity Progress Notes from the 2/1/17 thru 2/24/17 identified the 1:1 visits consisted of asking how her day was, and the weather. R23's response was she wanted to be moved in bed, wanted a drink, her bathroom door close, and other care requests.

Review of the January 2017 JPECC Activity Flow Sheet identified R23 had 13 1:1 visits. Review of the Activity Progress Notes from 1/3 to 1/30/17, identified the 1:1 visits consisted of asking about the residents mood, how her day was, weather, and her family. R23's response was she was fine, complained about not being able to move her arms, and was uncomfortable. She requested staff to reposition her, help her get a drink or do other various things in her room.

Review of the December 2016 JPECC Activity Flow Sheet identified R23 had ten 1:1 visits, and not twelve 1:1 visits as identified by the care plan. Review of the Activity Progress Notes from 12/5 thru 12/25/16, identified the 1:1 visits consisted of asking how she felt, how her day was and her family. R23's response was complaining that someone under her bed, burning

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and fire. The notes also identified R23 did play bingo in the evenings.

During interview on 3/9/17 11:40 a.m. Activity Assistant (AA)-A stated R23 does come to some activities but it varies depends on how she is feeling. At 12:00 p.m. AA-B stated she does 1:1 visits with R23, but she was unsure of what her likes, past preferences or what things to talk with R23 about. We ask her how she feels, and then she makes us do thing for her like getting a sip of water, helping her move or doing other things for her in her room.

During interview on 3/9/17 at 1:30 Activity Director (AD) stated they use the facility Activity Interview of Daily and Activity Preferences sheet and answered the questions. She stated they do not go into much detail about the areas on the interview sheet that would identify type of music, books, region or what their favorite activities were. AD stated they do not have an assessment that identifies their likes, dislikes or past experiences. They needed to develop something that will help them with their preferences and would assist staff when they do 1:1's with resident.

Although the facility activity assessment only identified how important certain aspects were to R23's life. The assessment did not identify R23 preferences, likes, dislikes or what specific things she enjoyed, or any past history which may assist in development of R23's 1:1 sessions with activity staff. Although R23 care plan identified she doesn't like group activities, her care plan directs staff to invite her to group activities. The care plan also identified R23 was to have three 1:1 visits each week, which did were not consistently

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implemented.

R9's annual Minimum Data Set (MDS) dated 1/31/17, indicated R9 was cognitively intact and had a diagnosis of depression. The MDS identified it was very important for R9 to do things with groups of people.

R9's medical record lacked a comprehensive activity assessment.

R9's care plan dated 5/28/16, indicated R9 was independent for meeting her emotional, intellectual and social needs. The care plan directed to "Provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self expression and responsibility." The care plan also indicated R9 preferred activities were: "going to the casino, current events, fish fry, movies, bingo, social time, women's group, saging and reading books."

During interview on 3/7/17, at 1:10 p.m. R9 stated there were not enough activities offered by the facility during the evenings.

During observation on 3/8/17, at 1:23 p.m. R9 was in the day room watching a movie with other residents and eating popcorn.

During observation on 3/8/17, at 2:28 p.m. R9 was in bed sleeping, while bingo was going on in the day room.

During interview on 3/8/17 at 6:04 p.m. nursing assistant (NA)-C stated at times R9 gets sad and anxious. NA-C stated that R9 enjoys outings to the casino , shopping and movies. There was nickel bingo after six in the evening about three

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times a week. Nickel bingo used to be everynight of the week, however; due to a lack of activity staff it had been reduced to three times a week. NA-C stated the only activity offered in the evenings was bingo.

During follow up interview on 3/9/17, at 7:09 a.m. R9 stated staff invited her to bingo the night before but she declined. R9 further stated the facility only has nickel bingo in the evenings and she didn't like nickel bingo. She didn't like bingo "all the time" and nothing else was ever offered in the evenings, like a movie or something else. R9 stated in the evenings she ended up watching television in her room or going to bed early, because she got bored. R9 stated she didn't recall anyone asking her, her likes and dislikes regarding activities, upon readmission to the facility in December.

R9's progress notes indicated the following:

- 2/9/17, at 1:27 p.m. R9 never came to bingo.
- 2/14/17, at 6:25 p.m. R9 declined to play nickel bingo.
- 2/17/17, at 3:23 p.m. R9 did not want to play prize bingo.
- 2/17/17, at 8:00 p.m. R9 declined to play bingo.
- 2/19/17, at 8:16 p.m. R9 declined to play bingo.

The facility activity calendars were reviewed from December 2016 through March 2017 and indicated the following:

- December 2016, included nickel bingo every evening at 6:30 p.m., it did not include any other activities in the evening.
- January 2017, included nickel bingo in evening at 6:30 p.m.,for all days except six days, it did not

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F 248	Continued From page 13 include any other activities in the evening. - February 2017, included nickel bingo in evening at 6:30 p.m.,for all days except seven days, it did not include any other activities in the evening. - March 2017, included nickel bingo in evening at 6:30 p.m.,for twelve days, it did not include any other activities in the evening. During interview on 3/9/17, at 11:41 a.m. NA-D stated the only activity offered in the evening was bingo. During interview on 3/9/17, at 1:49 p.m. the activity director (AD) stated that a comprehensive activity assessment had not been completed on R9, and currently was just completing the activity Activity Interview for Daily and Activity Preferences portion of the MDS, which was not comprehensive. The AD stated that R9's care plan was developed on what activities R9 attended had attended in the past. The AD further stated the only activity being offered in the evening was nickel bingo three times a week. The AD stated that she was hoping to increase activities next month, by increasing the staff numbers.	F 248		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.	F 309		4/18/17

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F 309	Continued From page 14 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure consistent foot support was provided for 1 of 3 residents (R5) reviewed for wheelchair positioning and whose feet were unsupported. Findings include: R5's quarterly Minimum Data Set (MDS) dated 12/6/16, identified R5 had severe cognitive impairment and hemiplegia (paralysis of one side of the body) with a, "Functional Limitation in	F 309	F309 Provide Care/Services for highest well-being. R5 does not require a custom wheelchair. the care plan for R4 was updated to reflect the resident's wheelchair positioning needs while in wheelchair. The plan of care was revised to encourage the resident to allow the placement of the foot platform to be on wheelchair, while the resident is up.	

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F 309	Continued From page 15 Range of Motion" on one side in her lower extremities. Further, the MDS identified R5 used a wheelchair for mobility and required extensive assistance with locomotion both on and off the unit. R5's care plan dated 2/22/17, identified R5 had, "An ADL [activities of daily living] self-care performance deficit," and required assistance to complete her ADLs. The care plan listed several interventions for the staff to implement which included, "LOCOMOTION: Resident uses custom wheelchair, staff to wheel her from one location to another. Unable to ambulate." The care plan did not address any specific interventions for R5's positioning in the wheelchair. During observation on 3/6/17, at 5:29 p.m. R5 was seated in a non-reclined position in a high back tilt-n-space wheelchair in the commons area by the dining room watching television. R5's knees were bent at a 90 degree angle and her feet were unsupported causing them to dangle with her left foot pointing downward while seated in the wheelchair. R5 stated her feet were, "Sore." When observed on 3/8/17, at 12:26 p.m. R5 was seated in the same high-back wheelchair in a reclined position by the nurses desk. R5's feet remained unsupported and dangling in the wheelchair with her left foot pointing downward. Further, during subsequent observation on 3/8/17, at 6:28 p.m. R5 was seated in her wheelchair in the day area by the nurses desk. However, R5 now had her feet supported with a black colored platform which caused her feet to not dangle.	F 309	All residents that use a customized wheelchair will be visually audited daily to ensure custom wheelchair has appropriate devices for that wheelchair in place for 2 weeks and then weekly for one month. The Therapy department will be involved in the communication process with the IDT team by attending morning stand up when their scheduled permits and during their weekly therapy meeting with rehab CNA and Nurse in order to provide up to date communication on any resident with changing needs as it relates to wheelchair positioning. Residents are screened on admission, every six months, if changes occur an updated plan is given to Charge Nurse and as needed/concerns arise in w/c positioning by OT/PT. A picture of each customized wheelchair with the correct devices will be put on the inside of the resident's closet so that staff is aware of how the customized wheelchair should appear when the resident is in the wheelchair. JPECC will provide mandatory staff education regarding the process changes as it relates to wheelchair positioning and the importance of correct wheelchair positioning on April 5th and 6th, 2017. The results of the wheel chair positioning audits will be reported to the QAA committee on 4-12-17. The Director of Nursing is responsible.	

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When interviewed on 3/8/17, at 6:39 p.m. nursing assistant (NA)-A stated R5's foot support had, "Always been there," since her shift started on 3/8/17, at 2:00 p.m. adding R5's foot support should always be in place when she was in her wheelchair.

During interview on 3/8/17, at 6:45 p.m. NA-B stated her, along with other NA staff, had assisted R5 to her wheelchair from bed earlier that day. NA-B stated after R5 was in her wheelchair, the occupational therapist (OT)-A entered R5's room and picked up the black foot support from a sitting chair along the wall. OT-A then placed it on R5's wheelchair.

When interviewed on 3/9/17, at 8:25 a.m. licensed practical nurse (LPN)-A stated R5 had used the tilt-n-space wheelchair for the past several months, using the black platform to, "Help support her feet." LPN-A stated R5 should be using the platform when she is seated in the wheelchair to, "Help prevent her feet from dropping down further than their supposed to be," adding the platform was, "Like a supportive device."

During interview on 3/9/17, at 12:55 p.m. registered nurse (RN)-A stated a resident should not be left in a wheelchair with their feet being unsupported.

When interviewed on 3/9/17, at 1:01 p.m. OT-A stated she was currently working with R5 for orthotic placement (hand splint) and had noticed R5's foot platform was not attached to her wheelchair on 3/8/17, and, "Thought it was strange." OT-A stated she found the platform in R5's room and then, "Put it back on." OT-A

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 17 stated R5 should have the foot platform in place when she is in the wheelchair, "To my knowledge," adding she had, "Never seen it not on," before. Further, OT-A stated residents should, "Have their feet supported in some way." An undated facility Repositioning Level II policy identified a purpose of, "The evaluation of resident repositioning needs," and "To promote comfort for all bed -or-chair bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents." However, the policy lacked any direction or procedures to ensure residents had proper wheelchair positioning including adequate foot support while using their wheelchair. A facility policy on wheelchair positioning was requested, but none was provided.	F 309		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.	F 323		4/18/17

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	245535	A. BUILDING ______ B. WING ______	C 03/09/2017

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F 323	Continued From page 18 (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess residents for safe smoking habits while residing in the facility for 2 of 3 residents (R1 and R17), reviewed for safe smoking. Findings include: R1 was admitted to the facility on 8/00. R1's diagnoses upon admission included cerebrovascular disease, unspecified. On 1/12/12, the diagnosis of nicotine dependence, unspecified, uncomplicated was added to the diagnosis listing. R1's quarterly Minimum Data Set (MDS) of 1/17/17 identified that resident was cognitively intact and required extensive assistance with activities of daily living including dressing and mobility. R1's care plan initiated on 9/10/15, and revised on 1/27/17, identified R1 was a smoker and denied desire for cessation. The interventions included staff instruction of resident about the smoking policy on smoking, locations, times, and safety concerns.	F 323	F323 Free of Accident Hazards,/Supervision/Devices Revised smoking assessment has been completed on R1 and R17. The care plan for R1 and R17 has been revised to reflect the smoking assessment results. Residents will be encouraged to smoke in designated area and per plan of care. No smoking signs are posted at wheelchair height. Residents R1 and R17 along with another varied resident that smokes will be visually audited daily to ensure safe smoking techniques occur for 2 weeks and then weekly for one month. The policy and procedure regarding the new system for smoking assessments was revised on 3-31-17. Re-education occurred immediately during survey to all residents that smoke regarding the policy on safe smoking. The safe smoking policy was reviewed and updated again on 3-31-17 and all smoking residents	

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F 323	Continued From page 19 On 3/7/17, at 2:05 p.m. R1 was observed lighting a cigarette inside the facility, near the activity door. Activity assistant (AA)-A, saw this, gasped, and then quickly assisted R1 outside to the designated smoking area. AA-A returned and stated she has seen R1 light his cigarette inside the building, and they watch residents so they do not do this. AA-A stated she spoke with R1 about not lighting his cigarette, and he understood the need to light the cigarette outside. She would let the nurse know what happened. AA-A went on to state that R1, "butted" his cigarette out and placed the unused portion of the cigarette back into the package of cigarettes. AA-A stated she had not seen any burn holes or burns on R1 from his cigarettes. On 3/7/17, at approximately 3:15 p.m. administrator (ADM) and director of nursing (DON) informed the survey team they followed up with R1 regarding lighting his cigarette in the facility. The ADM stated, R1 only initiated lighting his cigarette in the facility because of the extreme winds. R1 was aware of the facility policy and if there were ongoing problems, staff would then have to keep the cigarettes and matches on the medication cart. Review of R1's Smoking Safety Screen of 2/8/17 identified the "Resident alert and oriented x 3, demonstrates ability to smoke safely and unsupervised." Additional notes on this screen identified R1 "has been reminded of designated smoking area but has been witnessed smoking in other areas. Will review if resident continues to smoke in prohibited areas and implement restrictions per smoking policy." The smoking assessment did not identify R1 "butted" his cigarettes, and placed the unused portion back	F 323	updated on smoking policy on 4-3-17, 4-4-17 and 4-5-17. All staff and were educated on revised smoking policy on 4-5-17 and 4-6-17 and the corrective action that will be taking if unsafe smoking is observed. All residents that smoke will have revised smoking assessment completed and results will be reviewed with resident and care plan will be updated with current data. JPECC will provide mandatory staff education regarding the process changes as it relates to smoking and the importance of compliance. Findings will be brought to the QAA committee meeting on 4-12-17. The Director of Nursing is responsible.	

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F 323	Continued From page 20	F 323		

into the cigarette package.

During interview on 3/9/17, at 12:06 p.m. the ADM stated facility staff had noticed residents were lighting cigarettes inside the building before going out to the smoking area. He also added. that cigarettes are to be disposed of in the receptacle with no "No butting out". The ADM stated residents were to follow this policy or they would not be allowed independence with their cigarette use.

During interview on 3/9/17, at 12:56 p.m. nursing assistant (NA)-D stated R1 has been observed lighting cigarettes before exiting the building on more occasions, "Quite often" if the weather was cold. NA-D also stated R1 has smoked in front of the building, outside of the designated smoking area, on an almost daily basis. NA-D stated she had observed R1 light his cigarette between the entrance and exit doors when smoking in front of the building, beyond the designated smoking area.

During interview on 3/9/17 at 1:16 p.m. NA-E stated R1 had lit his cigarettes in the activity room at least monthly. He opened the door, lights a cigarette, and rolled out to the smoking area. NA-E stated R1 had previously attempted to smoke out in front of the building but had been instructed to only smoke in the designated smoking area.

Although R1 had unsafe smoking habits, which the facility was aware of. The facility had not comprehensively assessed R1's smoking habits to ensure he could safely smoke independently.

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R17's quarterly Minimum Data Set (MDS) dated 2/7/17, indicated R17 had moderate cognitive impairment and required limited assistance to areas off the unit.

R17's Admission Record (undated) identified diagnoses of peripheral vascular disease, repeated falls, bilateral age related macular degeneration, mild cognitive impairment and nicotine dependence.

R17's Smoking- Safety Screen- V2, dated 2/7/17, indicated R17 had a cognitive loss and a visual deficit. The smoking screen indicated R17 smoked two to five cigarettes a day at all times of the day. The smoking screen indicated R17 could light her own cigarette and didn't need adaptive equipment or the facility to store the resident's cigarettes and lighter. The screen indicated, "Resident refuses to wear smoking apron, has poor eyesight, dementia, fall risk. Is able to light own cigarette, staff continue to monitor resident for burns on clothing/skin. Resident refuses to throw away old clothing with cigarette burns. Encouraged to alert staff when going out to smoke. Resident has right to refuse interventions. Resident able to smoke unsupervised, will review if safety becomes a concern and implement restrictions per policy."

R17's care plan dated 4/18/16, indicated " The resident is a smoker. Resident is non-compliant with allowing staff to keep cigarettes, will acquire cigarettes without staff knowledge and put them in her purse/bra, non compliant about notifying staff when wanting to go smoke. Resident has been non- compliant and refuses to wear a smoking apron. Resident educated on the risks and benefits of smoking and declines smoking

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F 323	Continued From page 22 cessation at this time. Resident had clothing with cigarette burns upon admission and refuses to throw out damaged clothes. Trial use of electronic cigarette unsuccessful. Resident used intermittently, when out of regular cigarettes, but verbalizes desire for regular cigarette use." Interventions included were; " Encourage resident to store smoking supplies in the south med cart, encourage to let staff know when going out to smoke and encourage to wear a smoking apron, Instruct resident about the facility policy on smoking; locations, times, safety concerns, Observe clothing and skin for signs of cigarette burns q [every] NOC [night] shift and notify charge nurse if noted. Observe for any burns to clothing/skin and report to nurse if noted." R17's undated Visual/Bedside Kardex Report directed staff to " Observe for any burns to clothing/skin and report to nurse if noted." During observation on 3/6/17, at 2:50 p.m. R17 told a staff member she was going out to smoke. R17 used the automatic button to the courtyard door and wheeled herself in her wheelchair outside. R17 did not have a smoking apron on. R17 removed a cigarette and lighter from her purse and lit her cigarette. While smoking R17 brushed her hand over her pants several times. She then extinguished her cigarette in the ashtray, and wheeled herself back into the facility. R17 did not have any burn holes in her clothing or signs of ashes on her pants. During observation on 3/8/17, at 11:38 a.m. R17 was seated in her wheelchair smoking in the courtyard with an activity aid (AA)-B, R17 was not wearing an apron. When R17 finished smoking she extinguished the cigarette on her wheelchair	F 323		

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F 323	Continued From page 23	F 323		

wheel and brushed her hands over her pants. AA-B assisted R17 in her wheelchair back into the building. R17's clothing were free from burns and ashes.

During interview on 3/8/17, at 11:58 a.m. R17 stated she went out to smoke about three times a day, but "butted" (process of putting out a cigarette and saving it to smoke at a later time) her cigarettes, because she can't smoke an entire cigarette at a time. R17 stated she has not burned herself with a cigarette while being in the facility, and staff did not always go out with her outside, but some time they did. R17 stated she didn't wear an apron because she doesn't burn herself and kept her cigarettes and lighter on her because she paid for them and they were hers.

During interview on 3/8/17, at 12:00 p.m. AA-B stated R17 can smoke independently, but went outside to supervise R17 because it was so windy and didn't want her to get burned, due to the wind.

During interview on 3/9/17, at 11:38 a.m. nursing assistant (NA)-D stated the activity staff keep an eye on R17 when she went out to smoke. NA-D stated R17 had bad vision and felt someone should be watching her for safety. NA-D stated that R17 refused to wear an apron, so staff have stopped offering it. They are to observe her for burns and burn holes in her clothes and report any concerns to the nurse, and she has had no burns or injuries from smoking. NA-D stated R17 used to be supervised, but R17 became very upset over staff watching her so they changed her to an independent smoker. If residents violate the facility smoking policy nothing changes with the residents smoking privileges

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During interview on 3/9/17, at 12:39 p.m. AA-C stated that R17 usually only takes a "few drags" from her cigarette then butts it and saves it for later.

During follow up interview on 3/9/17, at 11: 49 p.m. R17 stated the previous nights she lit her cigarette in the facility before going outside and was told she couldn't do that. R17 also stated that someone had spoken with her today and told her she could no longer "butt" out her cigarette, which made her mad. She doesn't want to waste her cigarettes and can't smoke a whole one at one time. R17 stated she wasn't sure why staff didn't supervise her while smoking like they used to.

During follow up interview on 3/9/17, at 11:53 a.m. AA-C stated that R17 was caught lighting her cigarette inside the building the previous night, and reported the incident to a nurse. AA-C stated the activity department tried to supervise the smoking areas, however; they have not been directed to watch anyone in particular.

During interview on 3/9/17, at 11:57 a.m. the director of nursing (DON) stated the leadership team was looking at revising the facility smoking policy due to smoking incidents that have been brought to their attention. The DON further stated that previously when a resident violated the smoking policy, they just talked with the residents but the residents individual smoking privileges didn't change. The DON stated that R17 was previously supervised but showed that she could smoke independently as she had no incidents with burns. The DON further stated that R17's smoking assessment did not include lighting cigarettes inside the facility or assess R17's

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ability to safely "butt" her cigarettes for later use. The DON stated that R17 did not need an apron or have her cigarettes and lighter stored on the medication cart and the assessment was confusing.

During interview on 3/9/17, at 12:01 the nursing consultant (NC)-A stated that all residents are offered a smoking apron but R17 declined the use of one, and this was not clear in her smoking assessment. NC-A stated the facility met to discuss revising their policy due to residents lighting their cigarettes inside the building, and "butting" their cigarette and not properly extinguishing the cigarette. NC-A stated although resident input was important, their safety was the facility's main concern. NC-A stated the administrator was talking one on one with the residents who smoke, educating them on a new smoking contract.

An undated facility policy, titled Policy and Procedure: Smoking for JPECC (Jourdain Perpich Extended Care Center), identified "The facility shall establish and maintain safe smoking practices for residents who smoke while providing consideration for non-smoking residents. " The designated smoking area is outlined as the Gazebo, addressed under 4. a.. Smoking restrictions, addressed under 7 b., indicated "If safety is a concern, restrictions may be implemented such as monitoring smoking." Under the outlined under procedure, step 8. identified "Restrictions may be increased to the level of not allowing a resident to smoke if safety is deemed to be at a high-risk level as evidenced by resident refusing to allow staff to monitor for safe smoking, excessive falls while smoking, or burning self while smoking."

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F 428 SS=E	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		4/18/17

c) Drug Regimen Review

(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:

(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic.

(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.

(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.

(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.

(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to

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F 428	Continued From page 27 be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consulting pharmacist completed a comprehensive review of the medication regimen at least monthly for 5 of 5 residents (R12, R23, R5, R13, and R9), reviewed for unnecessary medication use. Findings include: R12's Pharmacist Medication Regimen Reviews, dated 4/20/16 through 3/8/17, identified a column of listed dates in which R12's medication regimen had been reviewed, with each date and "Comments/Recommendations," being provided and signed by the consultant pharmacist. The listing identified that R12's regimen had been viewed on the following dates: - 4/20/16, with "Recommend d/c [discontinue] hydroxyzine, No use in last month" identified; - 6/27/16 (68 days after last review), with "No issues," identified; - 8/18/16 (52 days after last review) with "No issues, "identified; - 9/30/15 with "No issues," identified; - 11/23/16 (52 days after last review), with "No	F 428	F428 Drug Regimen Review, Report Irregular, act on Resident R12, R23, R5, R13 and R9 have an up to date for March 2017, comprehensive review of their medication regiment done by the consulting pharmacist. All residents will be audited monthly to ensure that a comprehensive review of their medication regimen has been done by the consulting pharmacist, x2 months and then every other month for 4 months. The policy and procedure regarding the comprehensive medication regimen has been reviewed and revised on 3-31-17. DON will review monthly to assure all residents have had their comprehensive review of their medications has been completed by the consulting pharmacist. The results of the comprehensive review of resident medications by consulting pharmacist will be reported to the QAA	

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F 428	Continued From page 28 issues," identified; - 12/20/16, with "No issues," identified; - 1/25/17, with, ""No issues," identified and; - 3/8/17 (41 days after last review) with "No issues," identified. R12's medical record lacked any documented evidence R12 had been seen in the periods of missing dates identified on the medication regimen review listing. R23's quarterly Minimum Data Set (MDS) on 01/31/2017 identified a diagnosis of dementia, had severe cognitive impairment, and needed total staff assistance for activities of daily living. The facility monthly Pharmacist Medication Regimen Review forms from April 20, 2016 thru March 8, 2017 identified R23 was on medication for Lewy Body Dementia, depression, pain, diabetes , high blood pressure and atria fibrillation (quivering or irregular heart beat). The monthly pharmacist reviews from April 20, 2016 thru March 8, 2017 identified the pharmacist completed monthly reviews on the following dates: 4/20/16, no issues identified 6/27/16, (68 days after last review), with no issues identified 8/16/16, (50 days after last review), with no issues identified 9/29/16, no issues identified 11/21/16, (52 days after last review), and recommend family care planning for palliative care 12/20/16, comfort care only 1/25/17, no issues, comfort care	F 428	committee on 4-12-17. The Director of Nursing (DON) is responsible.	

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3/8/17, (41 days after last review) and recommend increase in pain medication

There were no indication in the medical record the pharmacy reviews were completed for the months of May 2016, July 2016, October 2016, and February 2017.

R5's Pharmacist Mediation Regimen Reviews dated 1/13/16 through 3/8/17, identified a column of listed dates in which R5's medication regimen had been reviewed with each date and, "Comments/Recommendations," being provided and signed by the consultant pharmacist. The listing identified R5's regimen had been reviewed on these dates:

- 4/20/16, with "No issues," identified;
- 6/27/16 (68 days after last review), with "No issues," identified;
- 8/1716 (51 days after last review), with "No issues," identified;
- 9/29/16, with "No issues," identified;
- 11/21/16 (52 days after last review), with "No issues," identified;
- 12/20/16, with "No issues," identified;
- 1/26/17, with, "Recommend to DC nystatin powder," identified and;
- 3/8/17 (40 days after last review) with "No issues," identified.

R5's medical record lacked any documented evidence R5 had been seen in the periods of missing dates identified on the medication regimen review listing.

R13's Pharmacist Mediation Regimen Reviews dated 1/14/16 through 3/8/17, identified a column of listed dates in which R13's medication regimen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING ______ B. WING ______	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	24856 HOSPITAL DRIVE REDLAKE, MN 56671

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 30	F 428		

had been reviewed with each date and, "Comments/Recommendations," being provided and signed by the consultant pharmacist. The listing identified R13's regimen had been reviewed on these dates:

- 4/21/16, with "No issues," identified;
- 6/29/16 (69 days after last review), with "No issues," identified;
- 8/18/16 (50 days after last review), with "No issues," identified;
- 9/30/16, with "No issues," identified;
- 11/23/16 (54 days after last review), with "No issues," identified;
- 12/21/16, with "No issues," identified;
- 1/25/17, with, "GDR attempts for Duloxetine and Seroquel," identified and;
- 3/8/17 (41 days after last review) with "No issues," identified.

R13's medical record lacked any documented evidence R13 had been seen in the periods of missing dates identified on the medication regimen review listing.

R9's Pharmacist Mediation Regimen Reviews dated 12/20/16 through 3/8/17, identified a column of listed dates in which R9's medication regimen had been reviewed with each date and, "Comments/Recommendations," being provided and signed by the consultant pharmacist. The listing identified R9's regimen had been reviewed on these dates:

- 12/20/16, with "No issues," identified;
- 1/26/17, with, "No issues," identified and;
- 3/8/17 (40 days after last review) with "d/c bubropion," identified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING ______ B. WING ______	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN PERPICH EXT CARE FAC	**24856 HOSPITAL DRIVE REDLAKE, MN 56671**

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F 428	Continued From page 31 R9's medical record lacked any documented evidence R9 had been seen in the periods of missing dates identified on the medication regimen review listing. During interview on 3/9/17, at 2:37 p.m. the consulting pharmacist (CP)-A stated the tribe had contracted with IHS (Indian Health Service) which was attached to the hospital, to conduct monthly pharmacy medication reviews. After CP-A reviewed the pharmacist medication review records, identified there were a few months of missing reviews. CP-A stated, there were two pharmacists that completed the monthly reviews, and the missed reviews could be due to scheduling issues.	F 428		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 441		4/18/17

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(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility’s IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the

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F 441	Continued From page 33 spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess, analyze, track and trend facility infections so effective interventions could be implemented to help minimize the risk of facility infections for 26 residents who resided in the facility. In addition, the facility failed to ensure hygienic cigarette lighting practices were implemented for 1 of 7 residents (R17) observed to be smoking. Findings include: The facility Infection Control Log's were reviewed for December 2016, January 2017, and February 2017. The logs included resident name, room, dates of treatment, date of onset, date of admission, admitted or acquired, type and site of infection, signs and symptoms, culture results, x-ray results, and antibiotic information. December 2016, Infection Control Log included five infections that were facility acquired but did not list signs and symptoms of the infection or a resolution date of symptoms to determine if the treatment was effective. The infections included a left breast infection, one urinary track infections, one wound infection, and one case of clostridium difficile (contagious bacteria causing severe diarrhea). The December analysis indicated that Tinea Pedis (fungal infection) continued to be a chronic issue for two to three residents who received ongoing treatments. The analysis did not	F 441	F441 Infection Control, Prevent spread, linens Corrective action will be accomplished by revising infection control log to allow adequate space for required information. Infection Control program will access, analyze, track and trend facility infections so effective interventions can be implemented to minimize the risk of facility infections. The facility will identify residents with infections via examination of the new orders, daily huddle and 24 hour report board and the monthly infection control log that is in place at nurses' station. The format of the facility surveillance program will include the comprehensive assessing, analyzing, tracking and trending the facility infections so interventions can be implemented to minimize the risk of facility infections for residents that reside at facility. Immediate re-education occurred with the activity aide (AA)-B on hygienic cigarette lighting. Policy and procedures for Infection	

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F 441	Continued From page 34 indicate an investigation for the chronic fungal infections, to include environmental cleaning or observation of personal cares to determine potential causal factors. There was no indication of how one resident could have developed a facility acquired breast infection. January 2017, Infection Control Log included eight infections that were facility acquired, but there was no listing of the residents signs and symptoms or a resolution date of symptoms to determine if the treatment was effective. The infections included one case of strep, one breast infection, four urinary track infections and two skin infections. The January analysis did not indicate any trends were identified. However, there was one breast infection in December 2016, with a subsequent breast infection, which developed in January of 2017, these residents were two rooms away from each other, and on the same side of the hallway. Also, the facility had an increase in urinary tract infections and there was no indication that an analysis was conducted as to why there was an increase in infections, or any interventions or surveillance the facility completed to help reduce the incidents of urinary tract infections. February 2017, Infection Control Log included three infections that were facility acquired, but did not identify the signs and symptoms of the infections or a resolution date of symptoms to determine if the treatments were effective The infections included one cellulitis of the feet, one fungal infection and one wound infection. February's analysis indicated no trends. However, the analysis lacked an investigation into the cause of the wound infection and a new onset of a fungal infection, which the facility has already	F 441	Control have been reviewed on 3-31-17. Policy and procedure for smoking has been reviewed and revised on 3-31-17. Resident R1 and R17 along with one other varied resident that smokes will be visually audited daily for 2 weeks, and then weekly for one month, to assure hygienic cigarette lighting occurs, audit is combined with F323. infection control will be audited daily x 2 weeks and then weekly for 2 months. Results of infection control and hygienic cigarette lighting will be reported to the QAA on 4-12-17. Residents that smoke were re-educated on hygienic cigarette lighting on 4-3-17, 4-4-17 and 4-5-17. JPECC will provide mandatory staff education regarding, reporting s/sx of infection in log at nurses station and on hygienic cigarette lighting on 4-5-17 and 4-6-17. Designed infection control nurse, with oversight of the Director of Nursing, will audit the comprehensive assessing, analyzing, tracking and trending of facility infections so effective interventions can be implemented.	

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identified as two-three residents having a chronic problem in their December 2016 analysis.

During interview on 3/9/17, at 7:41 a.m. the designated infection Preventionist registered nurse (RN)-B stated she obtained infection control information from working on the floor, report and looking at a log when medications were initiated. RN-B stated she tracked the information on the log and made sure the appropriate interventions to monitor resident infections were initiated. RN-B stated she looked for trends in infections on a weekly basis. RN-B stated the form she used didn't leave enough space to track the signs and symptoms of infections, so signs and symptoms were not tracked. RN-B also stated that she tracked the duration of the treatment of infections, but did not track the resolution dates of symptoms for infections, to determine if the treatment was effective. RN-B stated the only trends noted were in December regarding fungal infections but no investigation or surveillance was conducted to determine why and how to prevent reoccurrences. RN-B stated January's analysis did not identify an increase in urinary tract infections and had not noticed any patterns. RN-B stated the facility had improved their infection control monitoring in the last year but it still wasn't one hundred percent, and it does not get the commitment it deserves because of having numerous responsibilities within the facility.

During interview on 3/9/17, at 9:01 a.m. the director of nursing (DON) stated the facility was small and when RN-B worked she then collected the data needed to monitor infections. The DON stated that RN-B does an analysis of the infections and brings the information to the quality

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F 441	Continued From page 36 assurance meetings. The DON stated infections are to be reviewed for signs and symptoms for each residents and these signs and symptoms needed to be tracked. HYGIENIC CIGARETTE LIGHTING During observation on 3/8/17, at 11:38 a.m. R17 was seated in her wheelchair near the exit door to the courtyard. R17 had a previously smoked "butted" cigarette in her mouth but it was not lit. The activity aid (AA)-B assisted R17 to zip up her coat and then wheeled R17 out to the courtyard. R17 attempted to light her cigarette multiple times and was unable. AA-B attempted to light R17's cigarette, while R17 held the cigarette in her mouth but was unable to. R17 then handed her "butted" cigarette to AA-B. AA-B put R17's cigarette in her own mouth, lit it and handed it back to R17 to smoke. When R17 finished the cigarette AA-B pushed R17 in the wheelchair back into the building. During interview on 3/8/17, at 11:58 a.m. R17 stated she had AA-B assist her with lighting her cigarette today because it was so windy. During interview on 3/8/17, at 12:00 p.m. AA-B stated she lit R17's cigarette because it was so windy, and R17 asked her to light her cigarette. During interview on 3/9/17, at 8:04 a.m. RN-B stated staff should not be putting a cigarette in their own mouths and giving it back to a resident to smoke. That's a "huge no, no." RN-B further stated staff could have a virus or disease and could give it to the resident.	F 441		

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F 441	Continued From page 37 During interview on 3/9/17, at 9:01 a.m. the DON stated staff putting a cigarette in their own mouths and giving it back to a resident to smoke was unacceptable and the staff need to be re-educated. The facility policy Infection Control & Control Program dated 2/2/17, identified the facility would provide, "A system of surveillance, designed to identify possible communicable diseases or infections before they can spread to other persons in the facility."	F 441		
F 514 SS=C	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services	F 514		4/18/17

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F 514	Continued From page 38 provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician’s, nurse’s, and other licensed professional’s progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to document monthly pharmacy recommendations in the facility medical record for 5 residents (R12, R23, R5, R13, and R9), reviewed for unnecessary medication use. This practice had the potential to affect all 26 residents residing in the facility. Findings include: During review of R12, R23, R5, R13, and R9 medical record, there was no indication that monthly pharmacy reviews were in the facility's medical record for these residents. During interview on 3/9/17, at 8:38 a.m. the consulting pharmacist (CP)-A stated she and the other pharmacist completed the monthly pharmacy reviews, and kept their notes for the residents monthly medication reviews in a notebook. The CP-A stated any pharmacy recommendations are charted in the hospital system for the physician to review and sign, then are printed and given to the facility to place in the residents chart. The monthly pharmacy reviews were not part of the nursing home record, but	F 514	F514 Resident records-complete/accurate/accessible Resident R12, R23, R5, R13 and R9 have an up to date for March, 2017, pharmacy recommendations in the facility medication record. The policy and procedure regarding charting and documentation have been reviewed on 3-30-17. The pharmacist Teresa Grund at Red Lake Indian Health Service, was immediately educated on the policy and procedure regarding charting and documentation and the importance of residents having a complete chart. Pharmacists at Red Lake Indian Health Services have been given access to make notes in PCC regarding pharmacy recommendations. All residents will be audited monthly to ensure that pharmacy recommendations are in their facility medical record, x2 months and then every other month for 4 months. D.O.N. will review monthly to assure that	

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F 514	Continued From page 39 were kept at the hospital. During interview on 3/9/17, at 2:14 p.m. the director of nursing stated the pharmacy recommendations were filed in the residents facility chart, however; record of the pharmacist monthly review was not maintained in the residents facility medical record for any residents in the facility. During follow up interview on 3/9/17, at 2:37 p.m. the CP-A presented a pharmacy monthly medication review form for residents. The forms were in a three ring binder. The CP-A stated the form was used to document the pharmacist visits and noted if there were recommendations or not. The CP-A stated the form was not currently stored in the residents medical records in the facility. The CP-A further stated it would be easy enough to copy the form and place this in the resident charts in the facility, moving forward. The facility policy Charting and Documentation dated 4/08, indicated, "All services provided to the resident , or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record."	F 514	all residents have their pharmacy monthly medication review in their facility medical records The results of chart review will be reported to the QAA committee 4-12-17. D.O.N. is responsible.	

F5535026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING 01 - NURSING HOME B. WING ______	03/07/2017

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey The Jourdain/ Perpich Extended Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and 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. 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	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/05/2017

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

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ST. PAUL, MN 55101-5145, or

By e-mail to:
Marian.Whitney@state.mn.us
and
Angela.kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

The Jourdain/ Perpich Extended Care Center is a 1-story building without a basement. The building was constructed in 1989 and is of Type II(000) construction. An assisted living apartment building, constructed in 2006 is separated from the building with a 2-hour fire barrier to the west and a hospital building, built prior to the extended care building is separated with a 2-hour fire barrier is to the east. The building is divided into 3 smoke compartments with 1-hour fire rated barriers.

The building is fully sprinkler protected in accordance with NFPA 13 Standard for Installation of Sprinkler Systems . The facility has a manual fire alarm system with corridor smoke detection, smoke detection in all common areas and automatic fire department notification in

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JOURDAIN PERPICH EXT CARE FAC	**24856 HOSPITAL DRIVE** **REDLAKE, MN 56671**

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K 000	Continued From page 2 accordance with NFPA 72 "The National Fire Alarm Code". The facility was surveyed as one building. The facility has a capacity of 47 beds. At the time of the survey the census was 27 residents. The requirement at 42 CFR, Subpart 483.70(a) is **NOT MET** as evidenced by:	K 000		
K 324 SS=D	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		4/1/17

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245535	A. BUILDING **01 - NURSING HOME** B. WING ______	**03/07/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 324	Continued From page 3 This **STANDARD** is not met as evidenced by: Based on observation and staff interview the facility failed to provide supervision of the cooking equipment as stated in the Life Safety Code (NFPA 101) 2012 edition section 19.3.2.5.3. This deficient practice could, if turned on by accident allow for minor injury to a resident or cause a fire which could affect an undetermined amount of residents, staff and visitors. Findings include: On the facility tour between 9:30 am to 12:00 pm on 03-07-2017 observations and staff interview revealed the stove in the activity room was unattended and the power to it was left on. This deficient practice was verified by the Housekeeping Supervisor.	K 324	All staff have been educated on the use of cooking stove and have been informed that power switch in the activity room closet that controls the stove must be kept in the off position when the stove is not in use and supervised. A daily audit for one month and weekly for an additional two months will be conducted to verify that staff is shutting off the power to the stove after use. Administrator is responsible. Completion date is April 1, 2017	
K 712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This **STANDARD** is not met as evidenced by: Based on record review and staff interview the	K 712	The facility will conduct monthly fire drills.	4/18/17

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	245535	A. BUILDING **01 - NURSING HOME** B. WING	**03/07/2017**

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K 712	Continued From page 4 facility failed to provide documentation of fire drills at least quarterly on each shift as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all 27 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:30 am to 12:00 pm on 03-07-2017 record review and staff interview revealed one fire drill was missed in the fourth quarter of 2016 and one in the first quarter of 2017. This deficient condition was confirmed by the Facility Administrator.	K 712	All 3 shifts will have at least one fire drill per quarter. The Administrator will audit the fire drill records each month for one year to ensure that fire drills are occurring as specified. 3 fire drills (one on each shift) were completed the week of March 27th. Administrator is responsible. Completion date is April 18, 2017	
K 920 SS=E	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general	K 920		4/7/17

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	245535	A. BUILDING **01 - NURSING HOME** B. WING ______	**03/07/2017**

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K 920	Continued From page 5 precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure a multiple outlet connection was in accordance with the 2012 edition of NFPA 99 section 10.2.3.6 item 2 for total ampacity. This deficient practice could cause an overload of a circuit which could cause a power outage to necessary equipment or cause a fire. This could affect 12 of the 27 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:30 am to 12:00 pm on 03-07-2017 observations and staff interview revealed in resident room 179 a refrigerator plugged into a power strip and not directly into a wall outlet. This deficient practice was verified by the Housekeeping Supervisor.	K 920	All staff has been educated that extension cords and power strips are not to be used in resident rooms. The power strip in room 179 was removed on 3-7-2017 and the refrigerator is plugged in directly to the wall outlet. Administrator will conduct weekly audits for one month and 3 months thereafter in all resident rooms to ensure that extension cords and power strips are not being used in resident rooms. Administrator is responsible. Completion date is April 7, 2017	