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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 4GSV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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) **305 3RD AVENUE SW**
(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 **03/22/2012** (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 IMR	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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, HFE-NEII 03/29/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 03/29/2012 (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.
00400
(L31)

30. REMARKS
Posted 4/6/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/09/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

Provider Number: 24-5535
Item 16 Continuation for CMS-1539

At the time of the standard survey completed at this Special Focus Facility on January 26, 2012, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required. The facility was given an opportunity to correct before remedies were imposed.

On March 22, 2012, the Minnesota Department of Health and on March 6, 2012, the Minnesota Department of Public Safety completed a Post Certification Revisit and determined that the facility had achieved substantial compliance pursuant to the standard survey completed on January 26, 2012, effective February 22, 2012. Therefore, the remedies outlined in our letter dated February 6, 2012will not be imposed. See attached CMS-2567B for the results of the March 22, 2012 and March 6, 2012 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5535

March 29, 2012

Ms. Debra Vincent, Administrator
Jourdain/Perpich Extended Care Facility
305 3rd Avenue Sw
Redlake, Minnesota 56671

Dear Ms. Vincent:

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 February 22, 2012 the above facility is recommended 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.

Please contact me if you have any questions.

Sincerely,

Nicole Steege

Nicole Steege, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring

Telephone #: (651) 201-4124 Fax #: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 29, 2012

Ms. Debra Vincent, Administrator
Jourdain/Perpich Extended Care Facility
305 3rd Avenue Sw
Redlake, Minnesota 56671

RE: Project Number S5535023

Dear Ms. Vincent:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On February 6, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 26, 2012. 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.

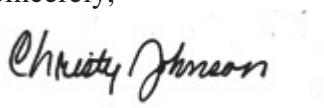
On March 22, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 6, 2012 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 26, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 22, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 26, 2012, effective February 22, 2012 and therefore remedies outlined in our letter to you dated February 6, 2012, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,



Christy Johnson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 308-2114 Fax: (218) 308-2122

Enclosure

cc: Licensing and Certification File 5535R12.rtf

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245535	A. Building B. Wing	3/22/2012

Name of Facility	Street Address, City, State, Zip Code
JOURDAIN/PERPICH EXT CARE FAC	305 3RD AVENUE SW REDLAKE, MN 56671

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **02/22/2012**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **02/22/2012**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **02/22/2012**
ID Prefix **F0313** Reg. # **483.25(b)** LSC	Correction Completed **02/22/2012**	ID Prefix **F0328** Reg. # **483.25(k)** LSC	Correction Completed **02/22/2012**	ID Prefix **F0364** Reg. # **483.35(d)(1)-(2)** LSC	Correction Completed **02/22/2012**
ID Prefix **F0411** Reg. # **483.55(a)** LSC	Correction Completed **02/22/2012**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **02/22/2012**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** CJ/NCS	**Date:** 03/29/2012	**Signature of Surveyor:** 28035	**Date:** 03/22/2012
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 1/26/2012

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245535	A. Building B. Wing **01 - NURSING HOME**	3/6/2012

Name of Facility	Street Address, City, State, Zip Code
JOURDAIN/PERPICH EXT CARE FAC	305 3RD AVENUE SW REDLAKE, MN 56671

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **02/22/2012**	ID Prefix	Correction Completed **02/22/2012**	ID Prefix	Correction Completed **02/22/2012**
Reg. # **NFPA 101** LSC K0018		Reg. # **NFPA 101** LSC K0021		Reg. # **NFPA 101** LSC K0050	
ID Prefix	Correction Completed **02/22/2012**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0054		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By State Agency	**Reviewed By** PS/NCS	**Date:** 03/09/2012	**Signature of Surveyor:** 03006	**Date:** 03/06/2012
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 1/24/2012

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 4GSV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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) **305 3RD AVENUE SW**
(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 **01/26/2012** (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 IMR	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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Stefani Anderson, HFE-NEII 02/27/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege,Program Specialist 03/07/2012 (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.
00400
(L31)

30. REMARKS
Posted 3/9/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

Provider Number: 24-5535
Item 16 Continuation for CMS-1539

At the time of the standard survey completed on January 26, 2012, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

This is a Special Focus Facility.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 2468

February 6, 2012

Ms. Debra Vincent, Administrator
Jourdain/Perpich Ext Care Fac
305 3rd Avenue Sw
Redlake, Minnesota 56671

RE: Project Number S5535023

Dear Ms. Vincent:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On January 26, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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:

Christy Johnson
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933

Telephone: (218) 308-2114

Fax: (218) 308-2122

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 March 6, 2012, 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 March 6, 2012 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 April 26, 2012 (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 July 26, 2012 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

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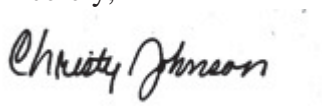
Feel free to contact me if you have questions.

Sincerely,



Christy Johnson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 308-2114 Fax: (218) 308-2122

Enclosure

cc: Licensing and Certification File 5535S12SFF.rtf

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 _____	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN/PERPICH EXT CARE FAC	305 3RD AVENUE SW 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 A recertification survey was conducted at the SFF (SPECIAL FOCUS FACILITY) to determine compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. THE FACILITY PLAN OF CORRECTION (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.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	F 225 2/22/12	F 225: The facility has re-educated staff regarding policies and procedures related to investigation and reporting of alleged violations involving maltreatment, or injures of unknown sources. Investigation reviewed for R 34. All residents could be affected if the facility fails to immediately report to the Administrator, Director of Nursing and to the appropriate state agencies. Facility staff will complete education regarding the Vulnerable Adult policy related to immediately reporting to the Administrator and Don if there is reason to believe maltreatment has occurred. DON/designee will audit 1-5 grievance/and or incident reports weekly for 60 days to assure proper reporting. Results of audits will be reviewed through QA. Completion: 2/22/12	2/22/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Debora J. Clement	Adm	2-21-12

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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F 225	Continued From page 1 The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of potential mistreatment and neglect had been reported to the State agency for 1 of 5 residents (R34) who were reviewed with an incident of potential verbal abuse by a staff member. Findings include: The undated Abuse Prevention policy, under	F 225		

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F 225	Continued From page 2 Reporting Abuse to Facility Management, indicated the administrator must be immediately notified of allegations of mistreatment and neglect and the administrator or his/her designee would immediately notify the State agency. R34 was diagnosed with a CVA (stroke). The quarterly Minimum Data Set (MDS) dated 10/13/11, identified R34 had no cognitive impairment and required extensive assistance from staff with all activities of daily living. On 1/24/12, at 9:40 a.m. R34 stated she had reported an incident related to nursing assistant (NA)-A which upset her. She stated R34 had come into her room to answer a call light and kept repeating, "Are you ready?" R34 stated she had needed assistance to the bathroom. The NA continued to repeat, "Are you ready?" This upset R34 and she stated she had asked the NA how many times she was going to repeat herself. The NA had stated, "50" to R34 and kept on repeating the statement. R34 stated the NA did eventually bring her to the bathroom, but the episode was upsetting. R34 stated she asked that the NA no longer work with her and reported the behavior to staff. An unnamed memo completed by the licensed social worker (LSW) dated 10/27/11, detailed the incident as R34 had described. The LSW requested that NA-A not care for R34. An unnamed memo completed by the director of nursing (DON) dated 10/28/11, indicated the DON sent a memo to the NA regarding the incident with R34. On 11/2/11, the memo indicated NA-A returned back to work and was	F 225		

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F 225	Continued From page 3 interviewed. NA-A denied the incident had occurred between R34 and the NA. NA-A was required to review the conduct and behavior policy with the DON and sign off that she had completed the education. On 1/25/12, at 6:06 p.m. the DON recalled the incident that R34 had reported, but stated it was not reported to the State agency. The DON stated NA-A was instructed that she could no longer work with R34 and was interviewed about the incident. On 1/26/12, on 12:21 p.m. the DON stated they had taken the situation seriously. She stated after reviewing the requirements this incident should also have been reported to the State agency immediately.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow established policy and ensure allegations of resident mistreament and neglect were reported to the State agency for 1 of 5 residents (R34) reviewed with an allegation of potential verbal abuse by a staff member. Findings include:	F 226	F 226: The facility has re-educated staff regarding policies and procedures related to investigation and reporting of alleged violations involving maltreatment, or injures of unknown sources. Investigation reviewed for R 34. All residents could be affected if the facility fails to immediately report to the Administrator, Director of Nursing and to the appropriate state agencies. Facility staff will complete education regarding the Vulnerable Adult policy related to immediately reporting to the Administrator and Don if there is reason to believe maltreatment has occurred. DON/designee will audit 1-5 grievance/and or incident reports weekly for 60 days to assure proper reporting. Results of audits will be reviewed through QA. Completion: 2/22/12	2/22/12

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F 226	Continued From page 4 R34 was diagnosed with a CVA (stroke). The quarterly Minimum Data Set (MDS) dated 10/13/11, identified R34 had no cognitive impairment and required extensive assistance from staff with all activities of daily living. On 1/24/12, at 9:40 a.m. R34 stated she had reported an incident related to nursing assistant (NA)-A which upset her. She stated R34 had come into her room to answer a call light and kept repeating, "Are you ready?" R34 stated she had needed assistance to the bathroom. The NA continued to repeat, "Are you ready?" This upset R34 and she stated she had asked the NA how many times she was going to repeat herself. The NA had stated, "50" to R34 and kept on repeating the statement. R34 stated the NA did eventually bring her to the bathroom, but the episode was upsetting. R34 stated she asked that the NA no longer work with her and reported the behavior to staff. An unnamed memo completed by the licensed social worker (LSW) dated 10/27/11, detailed the incident as R34 had described. The LSW requested that NA-A not care for R34. An unnamed memo completed by the director of nursing (DON) dated 10/28/11, indicated the DON sent a memo to the NA regarding the incident with R34. On 11/2/11, the memo indicated NA-A returned back to work and was interviewed. NA-A denied the incident had occurred between R34 and the NA. NA-A was required to review the conduct and behavior policy with the DON and sign off that she had	F 226		

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F 226	Continued From page 5 completed the education. On 1/25/12, at 6:06 p.m. the DON recalled the incident that R34 had reported, but stated it was not reported to the State agency. The DON stated NA-A was instructed that she could no longer work with R34 and was interviewed about the incident. On 1/26/12, on 12:21 p.m. the DON stated they had taken the situation seriously. She stated after reviewing the requirements this incident should have also been reported to the State agency immediately. The undated Abuse Prevention policy, under Reporting Abuse to Facility Management, indicated the administrator must be immediately notified of allegations of mistreatment and neglect and the administrator or his/her designee would immediately notify the State agency.	F 226		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide continuous nutrition through a gastrostomy tube in accordance with the resident's written plan of care for 1 of 1 resident (R43) reviewed in the	F 282	F 282 The facilities intent is to follow the resident's plan of care all staff were re-educated on following the resident's plan of care. for A nurse has been assigned to routinely check R 43 feeding tubes on a weekly basis times 90 days to assure on-going compliance to residents plan of care and to randomly audit all other residents who are receiving tube feedings to insure compliance. The Don or her designee will be monitoring on a weekly basis for 90 days then on a random basis. The QA team will be informed of any concerns or issues for input regarding policy and procedures. 2/22/12	2/22/12

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F 282	Continued From page 6 sample with a feeding tube. Findings include: R43's diagnoses included diabetes and a gastrostomy (g-tube feeding). The 5 day Minimum Data Set (MDS) dated 12/23/11, identified R43 as having severe cognitive impairment. The current plan of care dated 1/1/12, read for g-tube feedings as ordered. R43's physician's order dated 1/10/12, read for tube feeding at 80 cc an hour times 24 hours. On 1/26/12, from 7:30 a.m. until 9:35 a.m. R43 was not observed to receive his nutritional feeding via the gastrostomy. At 9:34 a.m. nursing assistant (NA)-A stated registered nurse (RN)-B had stopped the tube feeding at 7:30 a.m. when she took R43 over for lab work. At 9:35 a.m. RN-B stated he had been running behind this morning. RN-B stated he had looked at the medication administration record and noticed the nutritional feeding was to be continuous. RN-B stated that was "not good" when told the continuous feeding was a physician's order. RN-B verified the plan of care was not followed.	F 282		
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and	F 313	F313: The facilities intent is to establish and provide routine optical care and to assure that transportation is arranged. Corrective Action: Resident #5 appointment was rescheduled and completed on 2/3/12. A chart review of all current residents was completed and charts were updated to reflect the resident's current status. Appointments scheduled as needed. All staff re-educated regarding appropriate optical appointments and needs. Nursing responsible for appointments were re-educated to follow policy on providing appropriate care and interventions in a timely manner. The ward clerk will be responsible for updating the residents chart upon admission and following any appointments. The MDS coordinator will also review on a quarterly basis to assure that appointments and interventions were completed. The Don or her designee will be monitoring on a weekly basis for 90 days then on a random basis. The QA team will be informed of any concerns or issues for input regarding policy and procedures. 2/22/12	2/22/12

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F 313	Continued From page 7 by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to arrange an appointment and transportation for vision services for 1 of 3 residents (R5) in the sample that was identified to require these services to evaluate eye complaints. Findings include: R5's quarterly Minimum Data Set (MDS) dated 11/11/11, indicated R5 had no cognitive impairment and had impaired vision. The plan of care (POC) dated 2/15/11, indicated R5 was blind in one eye and had poor eyesight. The POC directed staff to coordinate yearly eye exams, and as needed. In addition, R34 was noted to have refused an eye appointment on 8/12/11. A revision to the POC dated 11/18/11, directed staff to assist R5 to follow up with the local eye center to evaluate eye complaints. The Provider Update on Resident Status form dated 11/18/11, indicated staff notified the physician of R5's complaints of her eyes watering. The physician directed staff to follow up with an optometrist at the local eye clinic for eye complaints. On 11/18/11, the Physician Orders identified an	F 313		

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F 313	Continued From page 8 order for R5 to follow up with an optometrist at the local eye clinic for eye complaints. No further documentation in the record indicated R5 had followed up with an optometrist as ordered by the physician. On 1/26/12, at 1:15 p.m. registered nurse (RN)-A stated they could not find any indication that the facility had followed up on the physician orders for an optometrist visit.	F 313		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to administer continuous nutrition through a gastrostomy feeding tube according to the physician's order for 1 of 1 resident (R43) reviewed in the sample with a feeding tube. Findings included:	F 328	F 328: The facility intent is to ensure that residents receive appropriate continuous nutrition through a gastrostomy feeding tube according to the physician's orders. All staff were re-educated on the policy and procedures regarding gastrostomy feeding tubes and as applicable to R 43 and other residents receiving tube feedings via a gastrostomy feeing tube. A nurse has been assigned to routinely check feeding tubes on a weekly basis times 90 days to assure on-going compliance. The Don or her designee will be monitoring on a weekly basis for 90 days then on a random basis. The QA team will be informed of any concerns or issues for input regarding policy and procedures. 2/22/12	2/22/12

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F 328	Continued From page 9 R43's diagnoses included diabetes and a gastrostomy (g-tube feeding). The 5 day Minimum Data Set (MDS) dated 12/23/11, identified R43 as having severe cognitive impairment. The current plan of care dated 1/1/12, identified g-tube (gastrostomy) feedings as ordered. The physician's order dated 1/10/12, directed for g-tube feeding at 80 cc an hour times 24 hours. On 1/25/12, at 7:03 p.m. licensed practical nurse (LPN)-A stated R43's feeding was continuous. On 1/26/12, at 7:38 a.m. R43 was not in his room. At that time, registered nurse (RN)-B stated R43 was over at the lab having lab work done. At 7:50 a.m. nursing assistant (NA)-A brought R43 back to his room after the completed lab work. At 7:54 a.m. R43 was in his room and the nutritional feeding was not being administered. At 8:35 a.m. the nutritional feeding was still off. R43 was in bed asleep. At 8:50 a.m. R43's nutritional feeding was still off.	F 328		
	At 9:13 a.m. the nutritional feeding remained off. At 9:34 a.m. NA-A stated RN-B had stopped the tube feeding at 7:30 a.m. when she took R43 over for lab work. At 9:35 a.m. RN-B stated he had been was running behind this morning. RN-B had been passing medications and stated there were some			

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F 328	Continued From page 10 medications that were not on the cart so he had to run for them. RN-B stated he had looked at the medication administration record and noticed the nutritional feeding was to be continuous. RN-B stated that was "not good" when told the continuous feeding was a physician's order. RN-B stated he was going into the resident's room and would start the feeding. (The feeding was off from 7:30 a.m. until 9:35 a.m.)	F 328		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents received palatably hot food for 1 of 18 residents (R16) who received all meals in the resident's room and reported cold food. Findings include: On 1/23/12, at 9:03 a.m. R16 stated about a month and a half ago, he received three pancakes for breakfast that were ice cold. He stated there was no cover over the plate. He stated he could have tossed the pancakes like a Frisbee. R16 stated he told the nurse and also showed the nurse the pancakes. R16 stated he ate all his meals in his room.	F 364	F 364: It is the facilities intent to assure that each resident receives food prepared by methods that conserve nutritive value, flavor, and appearance; and that the food is palatable, and attractive, and at the proper temperature. All staff were re-educated on policy and procedures of serving the food in a timely manner to assure that the food is served at the proper temperature. The facility is looking into purchasing a plate warmer to be utilized by the dietary department to ensure that food is served at the appropriate temperature. Additional staff has been assigned to assist in passing trays. The Don or her designee will be monitoring on a weekly basis for 90 days then on a random basis. The QA team will be informed of any concerns or issues for input regarding policy and procedures. 2/22/12	2/22/12

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F 364	Continued From page 11 On 1/25/12, at 3:50 p.m. the cook supervisor stated they used to have a heated cart, however, they did not anymore. She stated they used to have a plate warmer, however, they currently are not using one. She stated the food comes on a plate with a lid on it. The cook supervisor stated there were 18 residents that ate breakfast in their room and 16 residents that ate supper in their rooms. At 5:17 p.m. cook-A. was observed dishing up food trays. Dietary staff placed the trays into the cart which would be taken down to the nursing home. The dietary department food temperature log identified the ham as 198 degrees Fahrenheit (F), scalloped potatoes at 204 degrees F, and the California blend vegetable at 206 degrees F. The food was dished onto the plate and covered with a lid. At 5:24 p.m. nursing assistant (NA)-A came to the kitchen from the nursing home to pick up the food cart. At 5:25 p.m. the food cart left the kitchen. At 5:30 p.m. R16 was served his tray. NA-A was observed to not close the door tightly on the food cart after taking out the first tray. At 5:56 p.m. the last resident tray was served. At 6:00 p.m. the test tray was taken off the cart and the temperatures were taken of the food in the presence of the director of nursing (DON). The scalloped potatoes measured 136.9 degrees F, the ham measured 122.5 degrees F, and the	F 364		

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 _____	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN/PERPICH EXT CARE FAC	305 3RD AVENUE SW 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 364	Continued From page 12 California blend vegetable measured 111.5. degrees F. At 6:02 p.m. cook-A stated the food temperatures should be at 140 degrees. The temperatures were verified by the DON. Cook-A verified the plates were not heated, the cart was not heated and they did not use an enclosed heating system for the room trays. On 1/26/12, at 8:16 a.m. R16 stated the food is never hot, usually warm. At 8:18 a.m. R16 was served breakfast in his room. There was a slice of toast on a paper plate covered with a piece of foil. R16 stated the toast was cold. At 11:00 a.m. the cook supervisor stated she would want the food served at 140 degrees. She stated everything had changed and added, "We used to have a hot food cart, with one side hot and one side cold." She stated, "They don't make those kind of carts anymore." The cook supervisor stated they used to use china dishes in the plate warmer, and the food was hot and steamy. She added years ago a resident had been throwing the dishes and breaking them, so they went to polycarbonate plates. She stated those plates would melt in the plate warmer. She verified the food cart was not heated. The cook supervisor stated she checked the temperatures of the food at 4:50 p.m. last evening prior to the food going into the steam table. She stated she took the food directly out of the oven. She added staff started to dish up food at 5:15 p.m. for the supper cart.	F 364		

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F 364	Continued From page 13 The food temperature policy dated 5/17/05, indicated hot food should be above 140 degrees F.	F 364		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the necessary dental services to meet the needs for 1 of 3 residents (R16) in the sample identified to request dental services. Findings include: R16 was diagnosed with cognitive impairment and a seizure disorder. The initial Minimum Data Set (MDS) dated 9/7/11, identified loose fitting dentures.	F 411	F 411: The facilities intent is to establish and provide routine and emergency dental needs of each resident. Corrective Action: Resident # 16 appointment was rescheduled to February 14, 2012. A chart review of all current residents was completed and charts were updated to reflect the resident's current status. Appointments scheduled as needed. All staff re-educated regarding appropriate dental care and needs. Nursing responsible for appointments were re-educated to follow policy on providing appropriate care and interventions in a timely manner. The ward clerk will be responsible for updating the residents chart upon admission and following any appointments. The MDS coordinator will also review on a quarterly basis to assure that appointments and interventions were completed. The Don or her designee will be monitoring on a weekly basis for 90 days then on a random basis. The QA team will be informed of any concerns or issues for input regarding policy and procedures. 2/22/12	2/22/12

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F 411	Continued From page 14 The Dental Care Area Assessment (CAA) dated 9/7/11, indicated R16 had lower dentures, and had lost the upper. R16 was noted to take dentures out to eat and had stated his lower dentures were loose and he would like to go to the dentist. The CAA note indicated R16 would be scheduled for a dental exam. The plan of care (POC) dated 9/7/11, addressed the poorly fitting bottom denture and no upper denture. The POC indicated a dental evaluation of dentures/exam would be set up. In addition, it identified that a dental exam was rescheduled for 12/8/11. The care conference summary dated 1/4/12, read R16 would like new dentures and had an appointment coming up. On 1/25/12, at 2:17 p.m. registered nurse (RN)-A stated R16 had refused dental visits. At 2:25 p.m. RN-A stated there was no documentation in the clinical record that R16 had refused an appointment. RN-A stated the staff should document if a resident refused an appointment. On 1/26/12, at 8:16 a.m. R16 was observed to have bottom dentures that were loose fitting. R16 was also observed with no teeth on the top and no upper denture. At that time, R16 stated he could not wear the denture when he ate because they were too loose. R16 added in December a staff person had mentioned that he had a dental appointment coming up in a few days. However, he stated the appointment never happened.	F 411		

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F 411	Continued From page 15 At 7:32 a.m. RN-A stated there was no documentation in the medical record to indicate there had been a dental appointment made and refused by R16. At 12:40 p.m. RN-A stated there was no dental policy that addressed dental refusals. She stated it should be documented when a resident refused.	F 411		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their	F 441	F 441 The facilities intent is to establish and maintain an infection control program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Corrective action: all staff has been reoriented to following the facilities infection control policies for providing proper hand washing techniques as accepted practice following all resident contact and wound care. The Infection Control nurse will be monitoring random hand washing by staff on a weekly basis and applying interventions as needed. The DON or her designee will be monitoring on a weekly basis for 90 days then on a random basis. The QA team will be informed of any concerns or issues for input regarding policy and procedures. 2/22/12	2/22/12

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F 441	Continued From page 16 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to practice proper hand washing technique after a dressing change for 1 of 1 resident (R43) in the sample who was observed for wound care. Findings include: R43's diagnoses included a history of methicillin resistant staphylococcus aureus (MRSA) in his sputum, pressure ulcers, and had a gastrostomy (g-tube feeding). The 5 day Minimum Data Set (MDS) dated 12/23/11, identified R43 as having severe cognitive impairment. The current plan of care dated 1/1/12, identified a left outer knee wound and a right outer knee wound. Both of these pressure ulcers were a Stage 3 (full thickness tissue loss). On 1/25/12, at 7:03 p.m. licensed practical nurse (LPN)-A applied a gown, mask and gloves. LPN-A placed a mask on R43. A dressing was observed on the right outer leg. LPN-A removed the soiled dressing, then removed her gloves and	F 441		

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F 441	Continued From page 17 used hand sanitizer. LPN-A stated the wound had been draining more and the physician was aware. LPN-A then applied gloves, cleansed the area with normal saline (NS), removed her gloves, and used hand sanitizer. LPN-A then applied gloves, applied silvadene to the area with a sterile Q-tip, and covered the area with a dressing. LPN-A then removed her gloves and used hand sanitizer. At 7:13 p.m. LPN-A then applied gloves and removed the soiled dressing from the left outer leg. LPN-A then removed her gloves and used hand sanitizer. LPN-A then applied gloves, cleansed the area with (NS), removed her gloves, and used hand sanitizer. LPN-A then applied gloves, applied silvadene to the area with a sterile Q-tip, and covered the area with a dressing. LPN-A then removed her gloves and used hand sanitizer. At 7:18 p.m. LPN-A applied gloves and administered R43's medications via the gastrostomy tube. At 7:24 p.m. LPN-A removed her gloves, and used hand sanitizer At 7:26 p.m. LPN-A removed her gown and mask and used hand sanitizer. She applied gloves and then left the room. No hand washing had occurred at this time. At 7:43 p.m. LPN-A stated she used hand sanitizer after she removed her gloves, mask and gown, and did not wash her hands. LPN-A was observed at this time setting up medications for other residents and verified she should have	F 441		

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F 441	Continued From page 18 washed her hands. On 1/26/12, at 1:58 p.m. the director of nursing stated hand washing should have been completed after the dressing change according to the policy. The facility wound care policy revised 10/10, identified that staff should "wash and dry your hands thoroughly" after the completion of a dressing change.	F 441		

JOURDAIN / PERPICH
EXTENDED CARE CENTER

24856 Hospital Drive · PO Box 399 · Red Lake, MN 56671
Phone 218-679-3400 · Fax 218-679-3434 · jpecc@paulbunyan.net
www.jourdainperpich.org

February 21, 2012

Christy Johnson, R.N.
Unit Supervisor
Minnesota Department of Health
705 5th Street N.W.
Bemidji, MN 56601

Re: Provider Number 245535

Enclosed is the Plan of Correction for the survey conducted on January 26, 2012 of the Jourdain Perpich Extended Care Center.

Sincerely,

Debra J. Vincent

Debra J. Vincent
Administrator

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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 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 substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. ~~PLEASE RETURN THE PLAN OF~~ CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: PATRICK SHEEHAN ~~SUPERVISOR~~ STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST PAUL, MN 55101-5145 Email: pat.sheehan@state.mn.us	K 000	POC ok JR 2-27-12 RECEIVED FEB 27 2012 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 03.07.12
EXIT: 01.26.12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maija Sundquist DON — TITLE — (X6) DATE: 2/24/12

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

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K 000	Continued From page 1 Fax Number 651-215-0525 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 1999 edition. The facility has a manual fire alarm system with corridor smoke detection, smoke detection in all common areas and automatic fire department notification in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition and has automatic fire detection in all areas required by the Minnesota State Fire Code 2007 edition.	K 000		

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K 000	Continued From page 2 The facility was surveyed as one building. The facility has a capacity of 47 beds. At the time of the survey the census was 38 residents. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Observations showed that one of fifty corridor doors tested did not comply with NFPA 101 "The Life Safety Code" 2000 Edition Section 19.2.2.2. If corridor doors do not positively latch a fire could spread beyond the room of origin and would	K 018	K: 018 the door latch to the Break room has been repaired and latches appropriately. Maintenance will review/monitor areas weekly and the Administrator will monitor weekly for 90 days and then on a random basis thereafter. The Quality Assurance team will be informed of any concerns or issues for input regarding corrections, policy and procedures. 2/22/12	

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K 018	Continued From page 3 negatively impact all the patients, visitors and staff. Findings include: During the facility tour on January 24, 2012, between 8:45 am and 10:15 am, observations revealed that the employee break room corridor door latch stuck in the released position at times and would not hold the door closed. This finding was verified by the Administrator (DV) and the Director of Maintenance during the facility tour.	K 018		
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Observations revealed that two of six hazardous	K 021	K: 021 the boiler room door and west wing storage door have been closed, all staff re-oriented to assuring that doors are properly closed. Maintenance will review/monitor areas weekly and the Administrator will monitor weekly for 90 days and then on a random basis thereafter. The Quality Assurance team will be informed of any concerns or issues for input regarding corrections, policy and procedures. 2/22/12	

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K 021	Continued From page 4 areas are not in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.2.1. This deficient practice could allow the products of combustion to travel from one area to another if a fire occurs within this hazardous area, which could negatively impact all patients, visitors and staff. Findings include: During the facility tour on January 24, 2012, between 08:45 am and 10:15 am, observations revealed that the following hazardous area doors were being held open, but would not close upon fire alarm activation as required by NFPA 101 section 19.2.2.2.6: 1) The boiler room door was wedged open and 2) The west wing storage room corridor door was blocked open with a box. These findings were verified by the Administrator (DV) and the Director of Maintenance during the facility tour.	K 021		
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD 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 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2	K 050	K: 050 a fire drill calendar has been established to assure that drills are rotated to assure that all shifts are covered in each quarter and that all staff sign the fire drills. Maintenance will review/monitor areas monthly and the Administrator will monitor monthly to assure continued compliance. The Quality Assurance team will be informed of any concerns or issues for input regarding corrections, policy and procedures. 2/22/12	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOURDAIN/PERPICH EXT CARE FAC	305 3RD AVENUE SW 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 050	Continued From page 5 This STANDARD is not met as evidenced by: A review of fire drill records and an interview with staff revealed that the facility staff have not conducted fire exit drills in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.7.1.2. Not conducting fire exit drills could allow confusion and delay in the staff response, which would negatively impact all residents, visitors and staff in a fire emergency. Findings include: Prior to the facility tour on January 24, 2012, at approximately 8:40 am, a review of the Jourdain/ Perpich Extended Care Facility Fire Exit Drill report forms for 2011 revealed that, while 12 monthly fire drills have been conducted in 2011, the facility staff has not rotated shifts to insure each shift is drilled once a quarter as required by NFPA 101 section 19.7.1.2, nor do all the reports have signatures indicating which staff participated in the drills and various report forms are being used. These findings were verified by the Administrator (DV) and the Director of Maintenance during the facility tour.	K 050		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Observations revealed that two of approximately	K 054	— K: 054 Supply air diffusers were relocated by maintenance to assure that the distance from the fire detectors are 3 feet or more in distance. Maintenance will review/monitor areas monthly and the Administrator will monitor monthly to assure continued compliance. The Quality Assurance team will be informed of any concerns or issues for input regarding corrections, policy and procedures. 2/22/12	

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 _____	01/24/2012

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K 054	Continued From page 6 twenty corridor smoke detectors were not installed in accordance with NFPA 72 " The National Fire Alarm Code" 1999 edition section 2-3.5.1. Improper location of smoke detectors may allow a delay in alarming staff, causing a delay in the response to the fire emergency, which would negatively impact all the residents, visitors and staff. Findings include: During the facility tour on January 24, 2012, between 08:45 am and 10:15 am, observations revealed that the last smoke detector in each of the west and south wings were within 3 feet of the supply air diffuser. These findings were verified by the Administrator (DV) and the Director of Maintenance during the facility tour.	K 054		