



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 5, 2025

Licensee
Perham Living Northwinds
324 6th Ave Southwest
Perham, MN 56573

RE: Project Number(s) SL32603016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 29, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Jessie Chenze, Supervisor

State Evaluation Team

Email: jessie.chenze@state.mn.us

Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PERHAM LIVING NORTHWINDS	STREET ADDRESS, CITY, STATE, ZIP CODE 324 6TH AVE SW PERHAM, MN 56573
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	<p>Initial Comments</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>SL32603016</p> <p>On January 27, 2025, through January 29, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 11 residents; 11 receiving services under the Assisted Living Facility with Dementia Care license.</p>	0 000	<p>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.</p>	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PERHAM LIVING NORTHWINDS	STREET ADDRESS, CITY, STATE, ZIP CODE 324 6TH AVE SW PERHAM, MN 56573
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 550	Continued From page 1	0 550		
0 550 SS=F	<p>144G.41 Subd. 7 Resident grievances; reporting maltreatment</p> <p>All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, information about the facility's grievance procedure with the required content. This had the potential to affect the licensee's current residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p>	0 550		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PERHAM LIVING NORTHWINDS	STREET ADDRESS, CITY, STATE, ZIP CODE 324 6TH AVE SW PERHAM, MN 56573
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 550	<p>Continued From page 2</p> <p>The findings include:</p> <p>During the initial tour on January 27, 2025, at 11:40 a.m., with licensed assisted living director (LALD)-B, the surveyor observed the main entry to the facility with a phone to call to be let in. The inside consisted of common areas for the residents to sit and do activities and watch TV, a small kitchen serving area and dining room, and around the perimeter were resident rooms with a hallway where the residents could walk. Inside the front door, the surveyor observed a multiple items posted. However, the postings, lacked, in a conspicuous place, information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who were responsible for handling resident grievances.</p> <p>On January 27, 2024, at 1:00 9:00 a.m., clinical nurse supervisor (CNS)-A stated the information was not posted as required.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	0 550		
0 620 SS=D	<p>144G.42 Subd. 6 (a) / 626.557, Subd. 3</p> <p>Compliance with requirements for reporting ma</p> <p>(a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported.</p> <p>The requirement in Minnesota Statute section</p>	0 620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PERHAM LIVING NORTHWINDS	STREET ADDRESS, CITY, STATE, ZIP CODE 324 6TH AVE SW PERHAM, MN 56573
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	<p>Continued From page 3</p> <p>626.557, Subd. 3 is:</p> <p>(a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:</p> <p>(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or</p> <p>(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4).</p> <p>(b) A person not required to report under the provisions of this section may voluntarily report as described above.</p> <p>(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.</p> <p>(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.</p> <p>(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect</p>	0 620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PERHAM LIVING NORTHWINDS	STREET ADDRESS, CITY, STATE, ZIP CODE 324 6TH AVE SW PERHAM, MN 56573
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	<p>Continued From page 4</p> <p>according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report an incident of suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) for one of three residents (R4).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R4's diagnoses included Alzheimer's disease.</p> <p>On January 27, 2025, at 12:30 p.m., clinical nurse supervisor (CNS)-A stated R4 had an unwitnessed fall and was sent to the emergency department where it was determined she had a femur fracture. CNS-A stated a MAARC report had not been filed, but she had reported it on a website she found to report falls with fractures.</p>	0 620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PERHAM LIVING NORTHWINDS	STREET ADDRESS, CITY, STATE, ZIP CODE 324 6TH AVE SW PERHAM, MN 56573
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 620	<p>Continued From page 5</p> <p>An untitled and undated fall investigation noted R4 was heard to fall when they were assisting a resident across the hall and found R4 had attempted to self-transfer into bed.</p> <p>The licensee's Vulnerable Adult Maltreatment policy dated November 7, 2022, noted employees were responsible to report any suspected or observed maltreatment.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 620		
0 640 SS=F	<p>144G.42 Subd. 7 Posting information for reporting suspected c</p> <p>The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:</p> <p>(1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility;</p> <p>(2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and</p> <p>(3) providing reasonable accommodations with information and notices in plain language.</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting the 911 emergency number in common areas and near telephones provided by the facility</p>	0 640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PERHAM LIVING NORTHWINDS	STREET ADDRESS, CITY, STATE, ZIP CODE 324 6TH AVE SW PERHAM, MN 56573
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 640	<p>Continued From page 6</p> <p>as required. This had the potential to affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>During the initial tour on January 27, 2025, at 11:40 a.m., with licensed assisted living director (LALD)-B, the surveyor observed the main entry to the facility with a phone to call to be let in. The inside consisted of common areas for the residents to sit and do activities and watch TV, a small kitchen serving area and dining room, and around the perimeter were resident rooms with a hallway where the residents could walk. Inside the front door, the surveyor observed a multiple items posted. However, the postings, lacked the 911 emergency number in common areas.</p> <p>On January 29, 2024, at 8:30 a.m., LALD-B stated the information was posted outside the front door for visitors to see, but not in the common area.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	0 640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PERHAM LIVING NORTHWINDS	STREET ADDRESS, CITY, STATE, ZIP CODE 324 6TH AVE SW PERHAM, MN 56573
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 7	0 680		
0 680 SS=F	<p>144G.42 Subd. 10 Disaster planning and emergency preparedness</p> <p>(a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content defined in Appendix Z. This had the potential to affect residents receiving services under the assisted living license, staff, and visitors.</p> <p>This practice resulted in a level two violation (a</p>	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PERHAM LIVING NORTHWINDS	STREET ADDRESS, CITY, STATE, ZIP CODE 324 6TH AVE SW PERHAM, MN 56573
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	<p>Continued From page 8</p> <p>violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>During the initial tour on January 27, 2025, at 11:40 a.m., with licensed assisted living director (LALD)-B, the surveyor observed the main entry to the facility with a phone to call to be let in. The inside consisted of common areas for the residents to sit and do activities and watch TV, a small kitchen serving area and dining room, and around the perimeter were resident rooms with a hallway where the residents could walk.</p> <p>The licensee's EPP binder reviewed December 2024, lacked the following required content: - quarterly review of the missing resident plan.</p> <p>On January 29, 2025, at 8:47 a.m., clinical nurse supervisor (CNS)-A stated the missing resident plan was reviewed twice a year, typically with the staffing plan.</p> <p>The licensee's Elopement or Missing Resident policy dated March 1, 2024, noted the LALD and CNS must review the missing resident plan at least quarterly.</p> <p>Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care</p>	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PERHAM LIVING NORTHWINDS	STREET ADDRESS, CITY, STATE, ZIP CODE 324 6TH AVE SW PERHAM, MN 56573
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 9 facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PERHAM LIVING NORTHWINDS	STREET ADDRESS, CITY, STATE, ZIP CODE 324 6TH AVE SW PERHAM, MN 56573
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01060	<p>Continued From page 10</p> <p>resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.</p> <p>(c) The notice required under paragraph (b) must be delivered as soon as practicable to:</p> <p>(1) the resident, legal representative, and designated representative;</p> <p>(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and</p> <p>(3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.</p> <p>(d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. currently known; and</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, and designated representative, and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation for one of one resident (R3) who was hospitalized.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p>	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PERHAM LIVING NORTHWINDS	STREET ADDRESS, CITY, STATE, ZIP CODE 324 6TH AVE SW PERHAM, MN 56573
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01060	<p>Continued From page 11</p> <p>The findings include:</p> <p>R3's diagnoses included Alzheimer's disease.</p> <p>R3's service plan dated May 30, 2024, indicated R3 received services including assistance with toileting, grooming, dressing, and medication administration.</p> <p>On January 29, 2025, at 11:15 a.m., clinical nurse supervisor (CNS)-A stated R3:</p> <ul style="list-style-type: none"> - transferred to the emergency department on July 24, 2024; - remained in the emergency department on July 31, 2024, when CNS-A worked with a psychiatrist to get a medication management plan, and it was determined a geriatric psychiatric placement was recommended; - discharged to transitions unit in the skilled nursing facility (SNF) on August 8, 2024; and - returned to the emergency department from the SNF, and discharged to the transitions unit in the SNF. <p>At this time, CNS-A stated an emergency relocation had not been completed on R3, and stated they had been working with the OOLTC for their area, who told them they did not need to complete the emergency relocation form.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01060		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	01650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PERHAM LIVING NORTHWINDS	STREET ADDRESS, CITY, STATE, ZIP CODE 324 6TH AVE SW PERHAM, MN 56573
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	<p>Continued From page 12</p> <p>(f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a service plan included the required content for two of two residents (R1, R2).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to</p>	01650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PERHAM LIVING NORTHWINDS	STREET ADDRESS, CITY, STATE, ZIP CODE 324 6TH AVE SW PERHAM, MN 56573
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	<p>Continued From page 13</p> <p>cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).</p> <p>The findings include:</p> <p>R1 R1's diagnoses included Alzheimer's disease.</p> <p>R1's service plan dated December 27, 2024, indicated R1 received services including assistance with bathing, toileting, dressing, hygiene, and medication administration. However, it lacked: - a contingency plan that included the circumstances in which emergency medical services were not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.</p> <p>R2 R2's diagnoses included Alzheimer's disease.</p> <p>R1's service plan dated January 9, 2025, indicated R2 received services including assistance with bathing, toileting, dressing, transferring, and medication administration. However, it lacked: - a contingency plan that included the circumstances in which emergency medical services were not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.</p> <p>On January 28, 2025, at 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R2 in her apartment.</p>	01650		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PERHAM LIVING NORTHWINDS	STREET ADDRESS, CITY, STATE, ZIP CODE 324 6TH AVE SW PERHAM, MN 56573
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01650	<p>Continued From page 14</p> <p>On January 29, 2025, at 10:15 a.m., clinical nurse supervisor (CNS)-A stated this information was typically included on the service plan, but had been missed for R1 and R2.</p> <p>The licensee's Service Plan Assisted Living policy dated November 27, 2023, noted the service plan would include a contingency plan including the circumstances in which emergency services were not to be summoned.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01650		
01700 SS=F	<p>144G.71 Subd. 2 Provision of medication management services</p> <p>(a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.</p> <p>(b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others</p>	01700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PERHAM LIVING NORTHWINDS	STREET ADDRESS, CITY, STATE, ZIP CODE 324 6TH AVE SW PERHAM, MN 56573
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01700	<p>Continued From page 15</p> <p>who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for two of two residents (R1, R2) who received medication management services.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>During the entrance conference on January 27, 2025, at 11:15 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to residents at the facility.</p> <p>R1 R1's diagnoses included Alzheimer's disease.</p> <p>R1's service plan dated December 27, 2024,</p>	01700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PERHAM LIVING NORTHWINDS	STREET ADDRESS, CITY, STATE, ZIP CODE 324 6TH AVE SW PERHAM, MN 56573
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01700	<p>Continued From page 16</p> <p>indicated R1 received services including assistance with bathing, toileting, dressing, hygiene, and medication administration.</p> <p>R1's prescriber orders dated May 7, 2024, included a pain medication and an antipsychotic medication.</p> <p>R1's record lacked a medication assessment to include:</p> <ul style="list-style-type: none"> - an identification and review of all medications the resident is known to be taking; - indications for medications; - contraindications; - allergic or adverse reactions; and - actions to address these issues. <p>R1's January 2025, Medication Administration Record (MAR) listed medications as prescribed, times to administer, and staff initials through January 29, 2025, to indicate the medications had been given.</p> <p>R2 R2's diagnoses included Alzheimer's disease.</p> <p>R1's service plan dated January 9, 2025, indicated R2 received services including assistance with bathing, toileting, dressing, transferring, and medication administration.</p> <p>On January 28, 2025, at 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R2 in her apartment.</p> <p>R2's prescriber orders dated January 7, 2025, included a statin, an anti-diabetic medication, and a pain reliever.</p> <p>R2's record lacked a medication assessment to</p>	01700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER PERHAM LIVING NORTHWINDS	STREET ADDRESS, CITY, STATE, ZIP CODE 324 6TH AVE SW PERHAM, MN 56573
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01700	<p>Continued From page 17</p> <p>include:</p> <ul style="list-style-type: none"> - an identification and review of all medications the resident is known to be taking; - indications for medications; - contraindications; - allergic or adverse reactions; and - actions to address these issues. <p>R2's January 2025, Medication Administration Record (MAR) listed medications as prescribed, times to administer, and staff initials through January 29, 2025, to indicate the medications had been given.</p> <p>On January 29, 2025, at 10:15 a.m., clinical nurse supervisor (CNS)-A stated a medication reconciliation was competed monthly and this information was reviewed. However, it was not documented in the assessment as required.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01700		



MN Department of Health
 Food, Pools, and Lodging Services
 PO Box 64975
 St. Paul, MN 55164-0975
 218-332-5150

Type: Full
 Date: 01/28/25
 Time: 13:48:30
 Report: 7935251004

Food and Beverage Establishment Inspection Report

Location:

Perham Living Northwinds
 324 6th Ave Sw
 Perham, MN56573
 Otter Tail County, 56

Establishment Info:

ID #: 0039271
 Risk:
 Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2183471945
 ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
 Location: Wiping Cloth Bucket
 Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
 Temperature: 38 Degrees Fahrenheit - Location: Fridge 1
 Violation Issued: No

Process/Item: Cold Holding
 Temperature: 34 Degrees Fahrenheit - Location: Fridge 2
 Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

Type: Full
Date: 01/28/25
Time: 13:48:30
Report: 7935251004
Perham Living Northwinds

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the MN Department of Health inspection report number 7935251004 of 01/28/25.

Certified Food Protection Manager: Holly Kiehl

Certification Number: 110235 Expires: 03/20/25

Signed: _____
david.lilja@perhamhealth.org

Signed:  _____
Rebecca Tonneson
Public Health San Supervisor
Fergus Falls District Office
218-332-5142
rebecca.tonneson@state.mn.us