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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CLW612

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00438

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245486**

2.STATE VENDOR OR MEDICAID NO.
(L2) **847242400**

3. NAME AND ADDRESS OF FACILITY
(L3) **PERHAM LIVING**
(L4) **735 THIRD STREET SOUTHWEST**
(L5) **PERHAM, MN** (L6) **56573**

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 07/29/2019 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **96** (L18)
13.Total Certified Beds **96** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	96			
(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):

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 09/26/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 09/26/2019 (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
07/01/1987
(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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/25/2019
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 10, 2019

CMS Certification Number (CCN): 245486

Administrator
Perham Living
735 Third Street Southwest
Perham, MN 56573

Dear Administrator:

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 July 23, 2019 the above facility is certified for:

96 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 96 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 10, 2019

Administrator
Perham Living
735 Third Street Southwest
Perham, MN 56573

RE: Project Number S5486029

Dear Administrator:

On July 29, 2019, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CLW6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00438

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245486**

2.STATE VENDOR OR MEDICAID NO.
(L2) **847242400**

3. NAME AND ADDRESS OF FACILITY
(L3) **PERHAM LIVING**
(L4) **735 THIRD STREET SOUTHWEST**
(L5) **PERHAM, MN** (L6) **56573**

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 **06/13/2019** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **96** (L18)
13.Total Certified Beds **96** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	96			
(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):

17. SURVEYOR SIGNATURE Date :
Christina Martinson, HFE - NE II 07/15/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 07/24/2019 (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
07/01/1987
(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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
July 1, 2019

Administrator
Perham Living
735 Third Street Southwest
Perham, MN 56573

RE: Project Number S5486029

Dear Administrator:

On June 13, 2019, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is July 23, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

- Civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by September 13, 2019 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 13, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245486	A. BUILDING _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERHAM LIVING	735 THIRD STREET SOUTHWEST 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) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 6/13/19, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 6/10/19, 6/11/19, 6/12/19 and 6/13/19 a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Perham Living was found to not be in compliance with the regulations at 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a	F 623		7/23/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/08/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245486	A. BUILDING _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERHAM LIVING	**735 THIRD STREET SOUTHWEST 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) COMPLETION DATE
F 623	Continued From page 1 representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245486	A. BUILDING _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERHAM LIVING	**735 THIRD STREET SOUTHWEST 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) COMPLETION DATE
F 623	Continued From page 2 transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245486	A. BUILDING _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERHAM LIVING	735 THIRD STREET SOUTHWEST 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) COMPLETION DATE
F 623	Continued From page 3 written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the Long Term Care (LTC) Ombudsman of a facility initiated transfer for 1 of 3 residents (R86) reviewed for hospitalization. Findings include: R86's significant change Minimum Data Set (MDS), dated 4/5/19, indicated R86 had diagnoses which included atrial fibrillation (an irregular heart rate that commonly causes poor blood flow), heart failure, high blood pressure, and dementia. The MDS identified R86 had severe cognitive impairment and required extensive assistance with bed mobility, transfers, locomotion, dressing, toileting, personal hygiene and bathing. Review of R86's progress notes from 4/18/19, revealed the following: - on 4/18/19, at 10:33 a.m. R86 was noted to have minimal responsiveness. - on 4/18/19, at 10:59 a.m. R86's daughter was notified of R86's minimal intake and discussion was had whether R86 should be transferred to the hospital or not to be evaluated. R86's daughter requested time for her to have further discussions with other family members to	F 623	The Regional Ombudsman notified of error in the report regarding R86. Clarification from Ombudsman received. Procedure for notification of Ombudsman will be updated to meet all requirements. The Business Office and Social Services staff educated on regulation and Ombudsman expectations to ensure future compliance for all residents. All staff educated on notification requirements. The Social Services Director or Designee will complete an audit of Ombudsman notification for 3 months and review at QAPI to ensure effectiveness of corrections. Corrections will be in place by July 23, 2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245486	A. BUILDING _____ B. WING _____	06/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERHAM LIVING	**735 THIRD STREET SOUTHWEST 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) COMPLETION DATE
F 623	Continued From page 4	F 623		

determine if R86 should have been transferred to the hospital.

- on 4/18/19, at 2:49 p.m. the rest of R86's family members arrived and a decision was made to transfer R86 to the hospital to be evaluated.

- on 4/18/19, at 3:10 p.m. ambulance arrived to transport R86 to the hospital. R86's family expressed a desire to have intravenous therapy administered due to minimal intake as well as further testing to be completed.

The progress notes lacked any documentation the Ombudsman had been notified of R86's transfer to the hospital.

Review of the Action Summary form sent to the Ombudsman for April 2019, and May 2019, indicated R86 was not on the list of residents transferred to the hospital.

On 6/13/19, at 3:28 p.m. licensed social worker (LSW)-B stated the Ombudsman was provided a listing of residents transferred to the hospital on a monthly basis. LSW-B reviewed the summary form and confirmed R86 had not been listed on the form. LSW-B stated the facility had been contacted by the family sometime after the transfer to the hospital to inform them R86 would not be returning to the facility and as a result the facility had not included R86 on the list.

On 6/13/19, at 4:17 p.m. director of nursing (DON) stated the expectation was all residents who were transferred to the hospital to be included on the list to the Ombudsman. DON explained the business office compiled the summary reports sent to the Ombudsman. DON

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PERHAM LIVING	735 THIRD STREET SOUTHWEST PERHAM, MN 56573

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F 623	Continued From page 5 confirmed the progress notes lacked documentation of the Ombudsman receiving notification and confirmed R86 had not been included on the summary list sent to the Ombudsman for April 2019 or May 2019.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 625		7/23/19

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F 625	Continued From page 6 Based on interview and document review, the facility failed to provide notification to the resident and/or resident representative of the facility's bed hold policy at the time of the emergency transfer for 1 of 3 residents (R86) reviewed for hospitalization. Findings include: R86's significant change Minimum Data Set (MDS), dated 4/5/19, indicated R86 had diagnoses which included atrial fibrillation (an irregular heart rate that commonly causes poor blood flow), heart failure, high blood pressure, and dementia. The MDS identified R86 had severe cognitive impairment and required extensive assistance with bed mobility, transfers, locomotion, dressing, toileting, personal hygiene and bathing. Review of R86's progress notes from 4/18/19, revealed the following: - on 4/18/19, at 10:33 a.m. R86 was noted to have minimal responsiveness. - on 4/18/19, at 10:59 a.m. R86's daughter was notified of R86's minimal intake and discussion was had whether R86 should be transferred to the hospital to be evaluated. R86's daughter requested time for her to have further discussions with other family members to determine if R86 should have been transferred to the hospital. - on 4/18/19, at 2:49 p.m. the rest of R86's family members arrived and a decision was made to transfer R86 to the hospital to be evaluated. - on 4/18/19, at 3:10 p.m. ambulance arrived to	F 625	Discharge/Hospital Transfer checklist updated to include provision and documentation of bed hold information provided to resident and/or family member. Transfer note developed and implemented in EMR. This will remind staff of the need to provide a bed hold and document that the information was provided in the resident□s medical record. The bed hold policy and forms will be reviewed and revised as appropriate by nursing and social services staff to ensure accuracy and appropriateness. Education provided to all staff regarding the bed hold policy and process. The DON or Designee will complete an audit of bed holds provided to residents for 12 weeks and review at QAPI to ensure effectiveness of corrections. Corrections will be in place by July 23, 2019.	

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F 625	Continued From page 7 transport R86 to the hospital. R86's family expressed a desire to have intravenous therapy administered due to minimal intake as well further testing to be completed. The progress notes lacked documentation a bed hold notice had been provided to R86 or R86's representative upon transfer to the hospital. On 6/13/19, at 3:28 p.m. licensed social worker (LSW)-B stated the usual practice was to provide a bed hold notice to the resident and/or representative anytime a resident was transferred to the hospital. LSW-B confirmed there had been no bed hold notice provided to R86 or R86's representative at the time of the emergency transfer. On 6/13/19, at 4:17 p.m. director of nursing (DON) stated the expectation was all residents and/or representatives were to be provided a bed hold notice at the time of emergency transfer. DON confirmed the progress notes lacked documentation of the bed hold notice provided to R86 and/or representative and additionally confirmed R86 and/or representative had not received a bed hold notice. A policy of bed hold notice had been requested and not provided.	F 625		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		7/23/19

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F 689	Continued From page 8 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document interview, the facility failed to comprehensively assess smoking safety for 1 of 1 residents (R20) with currently smoked. Findings include: R20's Diagnoses Report dated 6/13/19 indicated R20 had diagnoses which included malignant neoplasm of lower lung, nicotine dependence, encounter for orthopedic aftercare following surgical amputation and depression. R20's quarterly Minimum Data Set (MDS) dated 4/12/19, indicated R20 was cognitively intact and required extensive staff assistance with transfers, toileting, and bathing and required limited assistance with bed mobility, personal hygiene, dressing. The MDS further indicated R20 had limited range of motion of lower extremity on one side and utilized a wheelchair and walker. R20's care plan, revised 6/10/19, indicated R20 had impaired cognitive function and or impaired thought processes related to dementia and history of inappropriate use of cigarette use within facility against policy secondary to cognitive impairment and was an elopement risk/wanderer secondary to his smoking addiction and cognitive impairment. The care plan listed various interventions which included: staff would give reminders, cues, reorientation, coaching conversations and/or discussion regarding alternative measures that may need to take place	F 689	A smoking contract is now in place with both R20 and FM-A. An assessment of resident□s condition completed and education provided to R20 and FM-A regarding the risks of smoking to the resident□s wellbeing based on assessment. All residents will be provided with smoking policy upon admission and the policy will be added to the admission checklist. Policy and procedure will be updated, as appropriate. A map will also be added to the smoking policy to ensure location of facility grounds is known to residents and families upon admission and at any time a review of policy is required. Any residents demonstrating behavioral concerns related to smoking or tobacco use will have their condition assessed to determine potential risks of smoking and education will be provided as needed. All staff educated regarding changes to policy and expectations regarding smoking and interventions. The Social Services Director or Designee will complete an audit of admissions checklists to ensure residents are made aware of smoking policies upon admission. Audits will also be completed one time per week for three months to ensure that all residents demonstrating behaviors related to smoking or use of tobacco have been assessed based on their condition to determine potential risks of smoking and	

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F 689	Continued From page 9 when R20 does not comply with request to be safe. Staff were to offer activities of interest such as structured activities, conversations, food, TV and books to deter R20 from asking about smoking. Staff were to ensure R20 handed in his cigarettes and lighting device upon each return from an outing and staff would locked up them up. Staff were to assist R20 in calling FM-A when he wanted to smoke. R20's care plan did not address the use of a wanderguard device. Review of R20's medical record did not include an assessment for R20's safety and smoking. A smoking assessment was requested for R20 and none was not provided. During observations on 6/11/19 at approximately 4:30 p.m. R20 was seated in his wheelchair in the hallway talking to trained medication aid (TMA)-A about going out to have a cigarette and stated to the TMA-A he had gotten some cigarettes from the gas station. On 6/12/19 at 8:29 a.m. R20 was seated on the edge of his bed with RN-A present. R20 stated "I will be going shopping for cigarettes." R20 requested she bring him his wallet back out of the medication drawer and stated "I need to get some cigarettes." RN-A gave R20 his wallet and proceeded to collect the dirty linen and garbage and exited the room. -at 12:28 p.m. R20 was seated in his wheelchair next to FM-A's pickup, in the parking area outside in the main entrance of the building, smoking a cigarette with FM-A present. On 6/13/19 at 9:29 a.m. RN-A confirmed R20's family members take R20 out to smoke and	F 689	education and interventions provided as needed. Corrections will be in place by July 23, 2019.	

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indicated FM-A had given R20 cigarettes in the past. RN-A indicated R20's lighter and cigarettes were to be locked up and indicated the facility was a non- smoking facility. RN-A indicated staff do not go out with R20 to smoke and that FM-A took R20 off of the premises to smoke.

In a follow up interview at 1:27 p.m., RN-A indicated FM-A has been educated on R20's cigarettes needing to be locked up and indicated since then she was aware R20 has had cigarettes and lighters at times when he was not supposed to have them. RN-A indicated R20 had smoked in the building at times, and had seen R20 carry used cigarette butts in the breast pocket of his shirt. She indicated she was aware R20 would hide his cigarettes in his socks and other places. RN-A indicated she felt R20 was a smoking hazard and was not sure where R20 has been getting his cigarettes, lighter or matches. RN-A indicated she was not aware of R20 smoking on the premises. RN-A indicated she was not sure if a smoking assessment had been completed on R20 for safety.

On 6/13/19 at 1:42 clinical manager (CM)-A stated she was aware R20 had smoked in his bathroom in the past.
CM-A confirmed R20's current care plan and confirmed an assessment had not been completed for R20's safety with smoking. CM-A indicated she felt R20 was a safety risk if he is smoking on the premises, having cigarettes and lighters and indicated she did not know if a smoking assessment would change anything.

On 6/13/19 at 10:59 a.m. TMA-A confirmed R20 was a current smoker and indicated R20's cigarettes and lighter were to be locked up in the

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medication room because the facility was a tobacco free campus. TMA-A indicated R20 would have cigarettes on him but not always a lighter and indicated R20 would always be looking for a lighter. TMA-A indicated staff were to try and distract R20 by offering coffee, conversing and that will usually help R20 to get it off his mind.

On 6/13/19 at 11:22 a.m. NA-A indicated staff have caught R20 with cigarettes and lighters on several occasions and have taken them away from him. NA-A indicated R20 has a wanderguard on because he had tried to go outside to smoke at times. NA-A has seen R20 with his cigarettes and lighter. She confirmed R20 had smoked in the building in the past.

Review of R20 Progress Notes from 4/22/19 to 6/13/19 identified the following:

- 4/22/19 at 11:07 p.m. R20 was in the hallway asking staff for a light, R20 indicated he wanted to light his cigarette as he held it in his hand. Staff told R20 the facility was a smoke free campus and he could not smoke inside or on the premises. R20 responded by saying "that's crap, I've done it before". R20 asked to have a cigarette a couple more times that evening and went to bed.

- 5/2/19 at 8:06 p.m. R20 was out in the hallway asking staff for light for his cigarette as he held it in his hand. Staff told him this was a smoke free campus.

- 5/10/19 at 1:28 p.m. last night R20 attempted to leave the unit to go the gas station to get a lighter or matches so he could smoke his cigarettes. R20 did have a pack of cigarettes on him and has

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F 689	Continued From page 12	F 689		

not tried to leave the unit today. At 3:37 p.m. R20 left the unit and was stopped by staff. R20 was asked where he was going he indicated he was going to go outside to smoke. Staff explained to R20 this was a non smoking facility and they would call his son. Staff called family member (FM)-A and left message and will continue to observe. At 6:36 p.m. R20 left the unit and staff asked where he was going, R20 indicated he was going outside to have a cigarette. Staff redirected by telling R20 it was supper time and R20 was agreeable. Question use of wander guard on R20's wheel chair appropriate, will route to register nurse and will continue to monitor. At 6:39 p.m. R20 left the unit and staff asked where he was going, R20 indicated he was going outside to have a cigarette. Staff indicated to R20 it was supper time, R20 replied he needed to smoke more than he needed to eat and indicated he would die if he did not have a smoke. Staff followed R20, retrieved him and reminded him this was a no smoking facility. R20's response was "bullshit".

- 5/11/19 at 2:14 p.m. R20 requested to go outside for smoke, staff explained to R20 he could not go outside to smoke unless his FM-A took him and R20 stated "well that's stupid." Staff called FM-A and indicated he was just at the facility and would be up later to take R20 out to smoke later in the evening. At 7:00 p.m. R20 has been at the door in the town center repeatedly, staff retrieve R20 brought back to unit and R20 stated "just get the hell away from me, I ' m going out to smoke." Staff explained to R20 that he could not go out to smoke and R20 stated just get the hell back in there and leave me alone." R20 was noted to be hiding behind the divider wall and peaking around looking for staff, so he could

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F 689	Continued From page 13	F 689		

sneak out the door of the facility. R20's FM-A here and took R20 outside for a little while. At 10:54 p. m. R 20 was telling staff he was going to light up the pack of cigarettes his family left him. Staff thinks R20 also has a lighter, which he denies and R20 will not allow staff to check his pockets. Message left with FM-A to inquire if they left lighter with R20.

- 5/12/19 at 2:09 p.m. R20 attempted twice to go outside to smoke this shift, doors locked due to wander guard and staff told R20 he could only go out to smoke when his FM-A was here. R20 stated "well that stupid" and wheeled himself back to his room. At 8:39 p.m. removed a pack of Pall Mall cigarettes, R20 had them laying out while at his bath and placed at nurses station.

- 5/15/19 at 10:15 a.m. R20's FM-A took cigarettes home, will review our policy with FM-A and R20. R20 was doing well in the past with nicotine patched to help with his smoking sensation. The warmer weather, being outside and smoking out of facility with family may also contribute to smoking cravings. Will offer and encourage smoking sensation options if having smoking cravings and will review use wander guard quarterly or as needed due to R20's smoking cravings that are contributing to his exit seeking.

- 5/19/19 at 9:10 p.m. R20 came out of room with cigarette tucked behind his ear and headed out to exit the building to find a match to lite his cigarette. R20 redirected and asked if he wanted FM-A called. Message left for FM-A, R20 went down to living room area, asked another resident if he had a match, resident stated no and R20 went back to his room. R20 then came back out

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F 689	Continued From page 14 of his room, asked another person if he had a match and proceeded to go back to his room for medications. - 5/22/19 at 10:41 a.m. R20's FM-A requested staff talk to him about not smoking on the premises and the policy. Staff explained to R20 that he cannot even have a cigarette in the building. R20's FM-A indicated he would take R20 out for a drive so he could have a cigarette. At 10:26 p.m. nurse was in den area when a smell of a freshly lit cigarette was notice. Nurse went into the hallway to find out where the smell was coming from. Nurse asked nursing assistant (NA) if she smelled the same thing and NA confirmed the smell of a lit cigarette smoke. Nurse followed the smell coming from R20's room, R20 was in his bathroom and asked R20 what that smell was and R20 replied it was the smell of a cigarette. Nurse asked R20 if he lit a cigarette in the bathroom and he replied he forgot he could not have a cigarette in his room. Nurse told R20 this was a non smoking facility and grounds, it was dangerous and hazardous to smoke in the bathroom. Nurse then asked R20 to hand over his cigarettes, R20 complied and nurse hid R20's cigarettes in the nursing den. At 10:47 p.m. R20 was entering nursing den looking for his cigarettes, nurse relocated R20's cigarettes and locked them in the medication room. - 5/25/19 at 2:38 p.m. R20 attempting to exit unit to go out to smoke, R20 had a pack of cigarettes and lighter on him and staff told R20 he could not have cigarettes and lighter on him at all. Cigarettes and light taken from R20 and locked up. R20's FM-A was called, message left alerting him to findings and was updated that this was a smoke free facility and this was a safety concern.	F 689		

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F 689	Continued From page 15 R20 was out with FM-A last evening for a car ride and will continue to monitor. At 4:37 p.m. R20 entered nursing den and want to know if staff had his cigarettes, R20 was informed that his cigarettes were locked up, R20 asked why staff took his cigarettes from him and staff told R20 they were not allowed on the grounds and they could not risk him lighting up in the building again. R20 asked when he was able to have his cigarettes back and staff told him when FM-A gets here. - 6/4/19 at 9:29 p.m. licensed pratical nurse (LPN) found unlit, broken cigarette in the hallway. Staff called R20's FM-A, he indicated he did not leave any cigarettes with R20 and indicated last week he found a lighter and matches on R20. R20's FM-A indicated R20 would not tell him where he got the matches and the lighter from. R20's son indicated he would stop up tomorrow to search R20's room to ensure that he does not have any cigarettes, lighter or matches in his room. R20's son wondering if other people are bringing R20 cigarettes, lighters and matches into the facility. - 6/10/19 at 11:47 p.m. R20 very anxious before and after supper wanting a cigarette. R20 was at the unit door many times sounding wander guard alert and trying to get out. R20 redirected and continued to attempt to get outside. R20's cigarettes remained locked up in the medication room. On 6/13/19 at 2:32 p.m. during a group interview with the director of nursing (DON) and social worker (SW)-A, SW-A confirmed R20 currently smokes and has been a life long smoker. The DON confirmed the facility does not complete smoking assessments because they are a smoke	F 689		

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F 689	Continued From page 16 free campus and do not allow smoking. The DON indicated they have confiscated cigarettes from R20 many times and have re-educated and tried to reinforce R20 not smoking. The DON indicated she has never seen R20 smoking and indicated she understood FM-A would take R20 for a drive to smoke. The DON indicated staff have never reported to her that R20 has been smoking on the campus grounds. The DON verified the parking area outside the main entrance was facility property and indicated R20 and FM-A should be following the facility policy. The DON and SW-B confirmed R20 was a smoking risk with R20 and FM-A not following the facility policy. Review of the facility policy titled, Resident and Family Smoking revised on 2/27/18, indicated residents/families are not allowed to use any form of smoking tobacco on Perham Living grounds. Resident who do smoke must be able to travel off campus to public property under their own power to smoke. If chewing tobacco or any of its forms including but not limited to dip, smokeless tobacco, snuff, and, spit tobacco is used spitting on Perham Health grounds was not permitted.	F 689		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the	F 756		7/23/19

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F 756	Continued From page 17 facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist (CP) identified and reported an irregularity related to the lack of psychotropic medication efficacy monitoring for 1 of 5 residents (R11) reviewed for unnecessary medications. In addition, the facility failed to ensure CP recommendations were acted upon in a timely manner for 1 of 5 residents (R70) reviewed for unnecessary medications.	F 756	R70s physician notified of pharmacy recommendation on June 14, 2019. The recommendation was addressed by the physician at that time. A review has been completed to ensure all other pharmacy recommendations have been brought to physician attention. To ensure all future pharmacy recommendations will be addressed in a timely manner, Consultant Pharmacist Drug Regimen Review Policy	

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F 756	Continued From page 18 Findings include: R11's admission Minimum Data Set (MDS) dated 6/22/18, indicated R11 had diagnoses of diabetes mellitus, anxiety and insomnia. The MDS identified R11 was cognitively intact and required extensive assistance with all activities of daily living (ADLs), except ate independently. The MDS further identified R11 had no behaviors, but had trouble falling or staying asleep, or slept too much. R11's quarterly MDS dated 3/21/19, indicated R11 had diagnoses of diabetes mellitus, anxiety and insomnia. The MDS identified R11 had moderate cognitive impairment and had no trouble falling or staying asleep, or sleeping too much. R11's Care Area Assessments (CAA) dated 6/24/18, indicated R11 received Trazadone (antidepressant) on a schedule to aid sleep, and indicated R11 slept without difficulty. The CAA further indicated R11 received antidepressants and monitoring was in place and/or had been set up in plan of care. R11's care plan, last reviewed 4/8/19, indicated R11 used psychotropic medication Trazadone to assist with insomnia. R11's care plan listed various interventions which included administer the medication as ordered, monitor and document for side effects and effectiveness, consult with pharmacy and doctor to consider dosage reduction when clinically appropriate, monitor/record occurrence of target behavior symptoms of sleeplessness and document, and monitor and record/report to physician as needed side effects and adverse reactions of psychoactive medications.	F 756	will be reviewed and updated, as appropriate. Education provided to nursing staff of policy and process and appropriate changes and all staff regarding the requirements and related policies. Timeliness of pharmacy consultant recommendations sent to and reviewed by physician will be audited by DON or Designee two times per month for three months and reviewed at QAPI. Corrections will be in place by July 23, 2019. R11 assessed for effectiveness of Trazadone and gradual dose reduction discussed with physician and family on June 14, 2019. All residents prescribed psychotropic medications for sleep assessed for effectiveness of medication. Policy reviewed and updated, as appropriate, for psychotropic medication use, assessment of effectiveness of medication, and monitoring. Education provided to nursing staff of policy and process changes and all staff educated regarding the requirements and related policies. DON or Designee will complete audits to ensure assessments completed for effectiveness of psychotropic medications for insomnia for two times per month for three months and reviewed at QAPI. Corrections will be in place by July 23, 2019.	

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Review of R11's Medication Administration Record (MAR) for June 2019, identified R11 received Trazadone 50 milligrams (mg) by mouth one time a day related to insomnia every night at bedtime, with a start date of 10/8/18.

Review of R11's Hypnotic/Sedative Medication Review dated 9/13/18, indicated R11 received Trazadone 50 mg for insomnia, with last dose change prior to admission. The form allowed areas to document non-pharmacological measures tried, benefits of the medication, or risks, however these areas were left blank. R11's physician indicated the medication worked for sleep, and R11 did not want to change. However, the form lacked an assessment of R11's sleep pattern.

On 6/13/19, at 9:03 a.m. registered nurse (RN) clinical manager (CM)-B indicated R11 received Trazadone for insomnia and had received Trazadone since prior to admission. CM- B stated R11 was due for a Gradual Dose Reduction (GDR) as she had been at the facility almost a year and the last GDR recommendation was on 9/13/18. CM-B stated staff do not monitor R11's sleep while taking Trazadone. CM-B indicated the facility did not have a policy or procedure for monitoring residents which received a psychotropic medication (Trazadone) for insomnia. CM-B stated the CP reviewed resident medications and if monitoring for effectiveness for Trazadone was not in place, CM-B would expect the CP to identify the lack of monitoring and recommend to put monitoring in place.

Review of R11's Pharmacist's Monthly Drug Regimen Review Form from 7/11/18 to 5/6/19,

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revealed the following:

-7/11/18, R11 admitted receiving Paxil (antidepressant), Trazadone, and Ativan (antianxiety medication) for a history of depression, insomnia and anxiety. Will allow time for resident to adjust to new living arrangements before addressing any potential dose reductions.

-9/12/18, "Consider reducing Trazadone or lorazepam [Ativan], increase paroxetine [Paxil]..."

No further comment or recommendation regarding Trazadone efficacy monitoring.

On 6/13/19, at 9:33 a.m. during an interview with the director of nursing (DON) and the assistant director of nursing (ADON), the ADON indicated nursing assistants completed flow sheets in each household that included hours of sleep for residents and these forms are reviewed daily, but not kept as part of the resident record. The ADON stated if a resident had specific sleep difficulties; the nurse would review that information in the Treatment Administration Record. The ADON indicated a lot of resident information came through shift to shift reports and if a resident was not sleeping well then that information would be brought up to the CM.

Review of R11's TAR from April 2019 to June 2019, indicated R11's side effect monitoring was completed monthly on the sixth of each month, however the TAR lacked any monitoring of R11's sleep or effectiveness of R11's Trazadone.

On 6/13/19, at 3:28 p.m. during a follow up interview with the DON and ADON, the DON indicated the CP's role was to identify and report

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medication irregularities. The ADON indicated nursing staff would monitor the effectiveness of an antidepressant used to treat insomnia by completing sleep studies, or reviewing hourly rounding sheets completed by nursing assistants.

On 6/13/19, at 12.33 p.m. during a telephone interview with CP-A, CP-A indicated her normal process at the facility included reviewing resident medication therapies, and make recommendations and identify irregularities and report those irregularities to facility staff. CP-A indicated if a resident received a psychotropic medication for insomnia, then she would expect to find monitoring of sleep. CP-A was unsure of the facility's process for monitoring the effectiveness of psychotropic medication used for insomnia, but would expect the facility's policy would define the appropriate procedure. CP-A stated the facility CM write a detailed summary every quarter and would expect to find a summary of sleep monitoring for a resident on psychotropic medication for insomnia.

Review of R11's RN Clinical Coordinator (RNCC) Quarterly Summary from 12/1/18 to 6/12/19, included:

-12/20/18, Psychotropic medication use: "[R11] sleeps well at night, takes trazadone 50 mg at bedtime to assist with insomnia. [R11] denies pain affecting her sleep. Will continue medications a[t] current dosage. Last GDR for Ativan, Paxil and Trazadone was 9/14/18 with no dose reductions advised."

-3/29/19, Quarterly review: "Uses trazodone 50 mg daily for sleep (insomnia) ...GDRs have beendone [sic] previously with no change in

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medication dosing. No side effects noted. Reports she sleeps well at night ...Plan: GDR when appropriate. Continue to monitor anxiety and depression. Continue to monitor side effects. No behaviors noted."

Review of R11's medical record lacked an assessment of R11's sleep to determine the effectiveness of Trazadone, or to provide documentation to support or deter a GDR.

R70

R70's admission Minimum Data Set (MDS) dated 11/14/18, indicated R70 had diagnoses of thyroid disorder, diabetes mellitus and arthritis. The MDS identified R70 was cognitively intact and required extensive assistance with dressing, supervision for toilet use, personal hygiene, eating, and was independent with all other activities of daily living (ADL).

R70's Care Area Assessments (CAA) undated, indicated R11 had a thyroid problem.

R70's care plan last reviewed 5/29/19, indicated R11 had a diagnosis of unspecified hypothyroidism (a condition in which your thyroid gland doesn't produce enough of certain important hormones), however R11's care plan did not address R11's hypothyroidism.

Review of R11's admission History and Physical (HP), dated 11/13/18, indicated R11 was admitted to the facility five days prior. R11's Active Problem List included a diagnosis of acquired hypothyroidism. The HP identified R11's last Thyroid Stimulating Hormone (TSH) (a test which measures the amount of TSH in the blood) was

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F 756	Continued From page 23 completed on 9/3/18. The HP further indicated "Thyroid medication should be continued without change given recent thyroid lab which was normal in September 2018." Review of R70's Order Summary Report indicated no currently ordered thyroid medication. Review of R70's Pharmacist's Monthly Drug Regimen Review Form from 12/14/18 to 5/6/19, indicated the following: -5/6/19: "Clarify whether [R70] should be receiving levothyroxine [hypothyroidism medication] per PN [physician/progress note] 4/19." Review of R70's physician progress notes from 12/22/18 to 6/10/19, indicated the following: -12/22/18, "hypothyroidism-stable." -1/21/19, "acquired hypothyroidism." -4/1/19, "4) hypothyroidism-continue replacement." -6/10/19, note indicated R70 was reviewed for pain and under the Active Problem List indicated "acquired hypothyroidism." The provider note lacked documentation that the pharmacist's recommendations was reviewed or actions taken to address the recommendations. Review of R70's progress notes on 5/30/19, indicated R70 was seen by physician on rounds. R70's medications and diagnoses reviewed and signed. The provider note lacked documentation that the pharmacist's recommendations was	F 756		

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reviewed or actions taken to address the recommendations.

On 6/12/19, at 11:37 a.m. registered nurse (RN) clinical manager (CM)-B stated awareness of CP-A's recommendation from 5/6/19, regarding R11's physician progress note which indicated R11 was to continue hypothyroidism replacement. CM-B stated she had checked R11's medical records through the hospital's electronic health record (EHR) that the facility was affiliated with, and there were no records R11 ever received medication therapy for hypothyroidism. CM-B indicated R11's medical records in the EHR did not go back too far, as prior to admission R11's primary physician worked with another hospital system, and CM-B did not have access to that system's EHR. CM-B stated R11's record lacked any TSH levels since admission, and stated she had not tried contacting R11's former primary provider from prior to admission. CM-B stated R11 was seen for regular rounds on 5/30/19, and again for a concern visit on 6/10/19, and CP-A's recommendation was not addressed with either provider visits. CM-B stated "I probably missed that on the last rounds, [R70] was just seen."

On 6/13/19, at 3:18 p.m. director of nursing (DON) stated CP-A reviewed resident medical records and identified any medication irregularities which are reported to nursing staff. The DON indicated CM-B would have received the recommendations from CP-A and would address the recommendation with the provider on the next physician rounds.

Review of facility policy titled Consultant Pharmacist Drug Regimen Review Policy, revised 3/14/18, indicated the CP would review the

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medical records and medication regiments of each resident for appropriateness using CMS (Centers for Medicare and Medicaid Services) Guidelines on Unnecessary Medications. The policy identified an unnecessary drug is any drug when used: "without adequate monitoring", and indicated any irregularities noted by the pharmacist during the review would be documented on a written report and provided to the attending physician, facility medical director, and DON. The facility further indicated irregularities requiring physician attention are intended to be addressed prior to or at the next scheduled physician (or designee) visit for the resident.

Review of the facility policy titled Psychotropic Medications last revised 7/24/18, indicated providers would use psychotropic medications appropriately working with the interdisciplinary team (IDT) to ensure appropriate use, evaluation and monitoring. The policy further indicated a psychiatrist/mental health may assist the facility in establishing appropriate guidelines for use, dosage and monitoring of psychotropic medications. The policy identified nursing staff would monitor psychotropic drug use daily, noting any adverse effects, monitor for the presence of target behaviors on a daily basis charting by exception and review the use of the medication with the physician and the IDT on a quarterly basis to determine the continued presence of target behaviors. The policy further identified the CP would monitor psychotropic drug use in the facility to ensure that medications are not used in excessive doses or duration and would notify the physician and the nursing unit if/whenever a psychotropic medication was past due for review. However, the policy lacked a procedure for

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F 756	Continued From page 26 assessing the effectiveness of psychotropic medications used for insomnia.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs	F 758		7/23/19

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F 758	Continued From page 27 are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure appropriate monitoring for efficacy of a psychotropic medication was completed for 1 of 5 residents (R11) reviewed for unnecessary medications. Findings include: R11's admission Minimum Data Set (MDS) dated 6/22/18, indicated R11 had diagnoses of diabetes mellitus, anxiety and insomnia. The MDS identified R11 was cognitively intact and required extensive assistance with all activities of daily living (ADLs), except ate independently. The MDS further identified R11 had no behaviors, but had trouble falling or staying asleep, or slept too much. R11's quarterly MDS dated 3/21/19, indicated R11 had diagnoses of diabetes mellitus, anxiety and insomnia. The MDS identified R11 had moderate cognitive impairment and had no trouble falling or staying asleep, or sleeping too much.	F 758	R11 assessed for effectiveness of Trazadone and gradual dose reduction discussed with physician and family on June 14, 2019. All residents prescribed psychotropic medications for sleep assessed for effectiveness of medication. Policy reviewed and updated, as appropriate, for psychotropic medication use, assessment of effectiveness of medication, and monitoring. Education provided to nursing staff of policy and process changes and all staff educated regarding the requirements and related policies. DON or Designee will complete audits to ensure assessments completed for effectiveness of psychotropic medications for insomnia for two times per month for three months and reviewed at QAPI. Corrections will be in place by July 23, 2019.	

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F 758	Continued From page 28 R11's Care Area Assessments (CAA) dated 6/24/18, indicated R11 received Trazadone (antidepressant) on a schedule to aid sleep, and indicated R11 slept without difficulty. The CAA further indicated R11 received antidepressants and monitoring was in place and/or had been set up in plan of care. R11's care plan, last reviewed 4/8/19, indicated R11 used psychotropic medication Trazadone to assist with insomnia. R11's care plan listed various interventions which included administer the medication as ordered, monitor and document for side effects and effectiveness, consult with pharmacy and doctor to consider dosage reduction when clinically appropriate, monitor/record occurrence of target behavior symptoms of sleeplessness and document, and monitor and record/report to physician as needed side effects and adverse reactions of psychoactive medications. Review of R11's Medication Administration Record (MAR) for June 2019, identified R11 received Trazadone 50 milligrams (mg) by mouth one time a day related to insomnia every night at bedtime, with a start date of 10/8/18. Review of R11's Hypnotic/Sedative Medication Review dated 9/13/18, indicated R11 received Trazadone 50 mg for insomnia, with last dose change prior to admission. The form allowed areas to document non-pharmacological measures tried, benefits of the medication, or risks, however these areas were left blank. R11's physician indicated the medication worked for sleep, and R11 did not want to change. However, the form lacked an assessment of R11's sleep pattern.	F 758		

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F 758	Continued From page 29 On 6/13/19, at 9:03 a.m. registered nurse (RN) clinical manager (CM)-B indicated R11 received Trazadone for insomnia and had received Trazadone since prior to admission. CM- B stated R11 was due for a Gradual Dose Reduction (GDR) as she had been at the facility almost a year and the last GDR recommendation was on 9/13/18. CM-B stated staff do not monitor R11's sleep while taking Trazadone. CM-B indicated the facility did not have a policy or procedure for monitoring residents which received a psychotropic medication (Trazadone) for insomnia. Review of R11's Pharmacist's Monthly Drug Regimen Review Form from 7/11/18 to 5/6/19, revealed the following: -7/11/18, R11 admitted receiving Paxil (antidepressant), Trazadone, and Ativan (antianxiety medication) for a history of depression, insomnia and anxiety. Will allow time for resident to adjust to new living arrangements before addressing any potential dose reductions. -9/12/18, "Consider reducing Trazadone or lorazepam [Ativan], increase paroxetine [Paxil]..." No further comment or recommendation regarding Trazadone efficacy monitoring. On 6/13/19, at 9:33 a.m. during an interview with the director of nursing (DON) and the assistant director of nursing (ADON), the ADON indicated nursing assistants completed flow sheets in each household that included hours of sleep for residents and these forms are reviewed daily, but not kept as part of the resident record. The ADON	F 758		

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stated if a resident had specific sleep difficulties; the nurse would review that information in the Treatment Administration Record. The ADON indicated a lot of resident information came through shift to shift reports and if a resident was not sleeping well then that information would be brought up to the CM.

Review of R11's TAR from April 2019 to June 2019, indicated R11's side effect monitoring was completed monthly on the sixth of each month, however the TAR lacked any monitoring of R11's sleep or effectiveness of R11's Trazadone.

On 6/13/19, at 3:28 p.m. during a follow up interview with the DON and ADON, the ADON indicated nursing staff would monitor the effectiveness of an antidepressant used to treat insomnia by completing sleep studies, or reviewing hourly rounding sheets completed by nursing assistants.

On 6/13/19, at 12.33 p.m. during a telephone interview with consultant pharmacist (CP)-A, CP-A indicated if a resident received a psychotropic medication for insomnia, then she would expect to find monitoring of sleep. CP-A was unsure of the facility's process for monitoring the effectiveness of psychotropic medication used for insomnia, but would expect the facility's policy would define the appropriate procedure. CP-A stated the facility CM write a detailed summary every quarter and would expect to find a summary of sleep monitoring for a resident on psychotropic medication for insomnia.

Review of R11's RN Clinical Coordinator (RNCC) Quarterly Summary from 12/1/18 to 6/12/19, included:

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-12/20/18, Psychotropic medication use: "[R11] sleeps well at night, takes trazadone 50 mg at bedtime to assist with insomnia. [R11] denies pain affecting her sleep. Will continue medications a[t] current dosage. Last GDR for Ativan, Paxil and Trazadone was 9/14/18 with no dose reductions advised."

-3/29/19, Quarterly review: "Uses trazodone 50 mg daily for sleep (insomnia) ...GDRs have beendone [sic] previously with no change in medication dosing. No side effects noted. Reports she sleeps well at night ...Plan: GDR when appropriate. Continue to monitor anxiety and depression. Continue to monitor side effects. No behaviors noted."

Review of R11's medical record lacked an assessment of R11's sleep to determine the effectiveness of Trazadone, or to provide documentation to support or deter a GDR.

Review of the facility policy titled Psychotropic Medications last revised 7/24/18, indicated providers would use psychotropic medications appropriately working with the interdisciplinary team (IDT) to ensure appropriate use, evaluation and monitoring. The policy further indicated a psychiatrist/mental health may assist the facility in establishing appropriate guidelines for use, dosage and monitoring of psychotropic medications. The policy identified nursing staff would monitor psychotropic drug use daily, noting any adverse effects, monitor for the presence of target behaviors on a daily basis charting by exception and review the use of the medication with the physician and the IDT on a quarterly basis to determine the continued presence of

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F 758	Continued From page 32 target behaviors. The policy further identified the CP would monitor psychotropic drug use in the facility to ensure that medications are not used in excessive doses or duration and would notify the physician and the nursing unit if/whenever a psychotropic medication was past due for review. However, the policy lacked a procedure for assessing the effectiveness of psychotropic medications used for insomnia.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free of significant medication errors for 1 of 1 resident (R11) who received another residents oxycodone (narcotic), had a decrease in respirations and was transferred to an emergency department for increased monitoring. Findings included: R11's admission Minimum Data Set (MDS) dated 6/22/18, indicated R11 had diagnoses of cancer, fracture, diabetes mellitus and anxiety. The MDS identified R11 was cognitively intact and required extensive assistance with all activities of daily living (ADLs), except ate independently. The MDS further indicated R11 was on scheduled and as needed (PRN) pain medication for frequent pain and an opioid was received each day of the assessment.	F 760	R11 assessed immediately following incident to ensure safety. All residents currently prescribed narcotics reviewed to ensure appropriate and accurate orders in place. Perham Living has implemented a new pharmacy system for single dose cards for all prescribed medications, which will mitigate risk to all residents. Education provided to nurse who made the error, as well as all other nursing staff and TMAs regarding safe medication administration and education provided to all staff regarding pharmacy services changes and applicable policies and procedures. DON or Designee will complete audits one time per week for twelve weeks of all medication incidents to ensure errors are identified, root cause completed, and education provided, as appropriate. DON or Designee will also audit one med pass per week for twelve	7/23/19

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F 760	Continued From page 33 R11's quarterly MDS dated 12/20/18, indicated R11 had diagnoses of cancer, spinal stenosis, diabetes mellitus and anxiety. The MDS identified R11 had moderate cognitive impairment and was on scheduled and as needed (PRN) pain medication for frequent, moderate pain and an opioid was received each day of the assessment. R11's Care Area Assessments (CAA) dated 6/24/18, indicated R11 required assistance with activities of daily living (ADL) at that time due to fracture and pain with movement. The CAA identified R11 received opioid medications and pain was managed. R11's care plan, last reviewed 4/8/19, indicated R11 was on pain medication therapy (hydrocodone-acetaminophen) related to spinal stenosis and lumbar one compression fracture. R11's care plan listed various interventions which included; administer medications as ordered, for respiratory depression: monitor respiratory rate, depth and effort after administration of pain medications, monitor for altered mental status, respiratory distress, sedation and observe for adverse reactions with every interaction with R11. Review of R11's progress notes from 1/1/19, indicated R11 was given the wrong medication. R11 was given Oxycodone 15 milligrams (mg) with Ativan (antianxiety medication) 0.5 mg and Trazadone (antidepressant medication used for sleep) 50 mg at bedtime. The progress note continued with an assessment of R11 which included "Respirations are shallow. MD [medical doctor] notified of error. New order received to monitor vital signs 2 hours. Call if respirations drop." "Respirations became 10 [per] minute. MD called and gave order to send to ER [emergency	F 760	weeks to ensure medication administration accuracy. Corrections will be in place by July 23, 2019.	

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room] for evaluation and monitoring. 911 called. EMS [emergency medical services] arrive at 2050 [8:50 p.m.] report given to them."

Review of R11's ER provider notes dated 1/1/19, indicated R11 was brought to the ER from the facility by EMS for evaluation regarding a medication error. R11 was administered Oxycodone instead of hydrocodone 2-3 hours prior to being transferred to the ER. R11's respiration rate went from 13 respirations per minute down to 10, without change to oxygen saturations. The note further indicated due to the medication error R11 was sent to the ER for evaluation, was alert and oriented and able to answer questions without difficulty.

On 6/13/19, at 3:32 p.m. registered nurse (RN) clinical manager (CM)-B indicated being the charge nurse on duty at the time of the error on 1/1/19, and was called by RN-B. CM-B stated RN-B indicated she had set up R70's Oxycodone 15 mg. Then RN-B stopped to assist R11 and decided to administer R11's bedtime medications which included Ativan 0.5 mg and Trazadone 50 mg. CM-B stated RN-B gave R11 the scheduled Ativan, Trazadone and R70's 15 mg of Oxycodone. CM-B indicated after the error was found, CM-B called the on-call physician at the hospital and received orders to monitor R11's respiratory rate. CM-B stated when R11's respiratory rate dropped from 13 to 10 respirations per minute she called EMS to send R11 to the ER for increased monitoring. CM-B stated education was given to RN-B that shift, but stated the education was not documented.

On 6/13/19, at 9:24 a.m. director of nursing (DON) stated the facility process followed after an

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identified medication error would be to fill out a Medication Error Tracking Form. The DON reviewed R11's medication error and indicated per the facility form, the medication error would have been a Level 3 error ("an error occurred that resulted in the need for increased patient monitoring with a change in vital signs but no ultimate harm...").

On 6/13/19, at 12:33 p.m. during a phone interview, consultant pharmacist (CP)-A indicated a significant medication error would be if a resident received another resident's medications, or an error which required increased monitoring. CP-A reviewed R11's medication error from 1/1/19, and stated "yes, that would be significant." CP-A stated she would expect to see education provided to the nurse, and would suggest completing audits to make sure the education was comprehended.

On 6/13/19, at 2:51 p.m. during a follow up interview, CM-B stated during the time period of RN-B's medication error, she was the facility's second shift supervisor. CM-B indicated if RN-B was assigned medication administration audits to determine RN-B's retention of re-education, she would have been the nurse's auditor. CM-B stated none were completed with RN-B. CM-B stated she would consider R11's medication error a significant medication error, as R11 was at risk for respiratory distress and could have coded.

On 6/13/19, at 3:32 p.m. during a follow up interview with the DON and ADON, the ADON stated she reviewed education with RN-B on RN-B's next shift worked. The ADON stated the education included to slow down and make sure RN-B was in the moment when administering

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F 760	Continued From page 36 medication, especially with high risk medications. The ADON stated RN-B's work flow was discussed and RN-B was reminded to ask coworkers for help when needed. The DON stated no audits of RN-B's medication administration were completed after the error, and added someone who made one error would not be audited. The DON stated she would not consider R11's medication error as significant, and if the facility would have considered it a significant error, their process would have remained the same. Review of the facility policy titled Medication Administration last reviewed 7/3/18, indicated it was the RNs duty to achieve the six rights of medication administration and to follow the procedural rules designed by the facility in order to produce the best resident outcomes. The policy listed the Six Rights as: Right resident name, Right drug, Right dose, Right route, Right time, Right documentation.	F 760		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		7/23/19

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F 880	Continued From page 37 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 38 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene was maintained during personal cares to prevent the potential for cross contamination/infection for 1 of 1 residents (83) reviewed for pressure ulcers. Findings include: R83's admission Minimum Data Set (MDS) dated 5/21/19, indicated R83 had diagnoses which included ulceritis colitis, septicemia, and enterocolitis due to clostridium difficile (C-diff)(bacterial infection causing diarrhea) and required staff assistance with activities of daily living. The MDS also indicated R83 was cognitively intact and was frequently incontinent of bowel with no toileting program and had a indwelling catheter. R83 current care plan revised on 5/23/19, indicated R83 had history of C-diff related to recent prolong antibiotic use secondary to sepsis. The care plan listed several interventions which included for staff to use contact precautions and to gown and glove when assisting with toileting,	F 880	Staff member (NA-A) educated on proper handwashing, isolation precautions, and infection control. Education provided to all staff proper handwashing, isolation precautions, and infection control. Infection Prevention and handwashing policies will be reviewed and updated, as needed. Audits completed by ADON or designee to ensure compliance with handwashing one time per week for 12 weeks. Corrections will be in place by July 23, 2019.	

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especially when in contact with bowel.

During observations on 6/12/19 at 7:40 a.m. R83 was seated on the edge of his bed, with a catheter bag attached to the bed frame, in street clothes, with nursing assistant (NA)-A present in the room, assisting him to finish dressing. NA-A removed her disposable gloves, and proceeded to assist him to ambulate into the bathroom and stand in front of the toilet. NA-A pulled his pants and incontinent product down and had him sit down on the toilet. R83 had a medium soft bowel movement in his incontinent pull up. NA-A removed R83's incontinent pull up with her bare hands and threw it in the garbage can next to the toilet. NA-A left the bathroom.

-At 8:06 a.m. NA-A put a yellow gown over her clothes and gloved her hands and proceeded to remove R83's pants, applied a clean pull up while pulling the catheter threw the leg and hooked on R83's walker. NA-A yellow gown was not tied in the back and the back of gown was noted to be flopping forward towards her arms while she worked with R83. She stated she had to wear a gown because R83 recently had C-diff and they are still doing precautionary measures in the bathroom only. R83 had a small bowl movement in the toilet and NA-A assisted R83 with peri cares. NA-A assisted R83 to stand, pulled up his incontinent product and his pants while she continued to wear her gloves. NA-A assisted R83 to tuck his shirt in, put his suspenders on while she continued to wear the same gloves. NA-A removed her gloves and gown and threw them in the garbage next to the toilet and indicated to R83 she would assist him to the dining room.

- At 8:17 NA-A assisted R83 to walk out of the

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F 880	Continued From page 40 bathroom with his walker and down the hallway to the dining room area. NA-A pulled out the dining room chair for R83 and assisted him to sit down at the dining room table. NA-A unhooked R83's catheter bag from the walker and hooked it on the left side of his chair. NA-A proceeded to walk over to the bathroom located near the dining room area and washed her hands. NA-A was not observed to properly glove and wash her hands while providing incontinent cares and assistance to the dining room for R83. On 6/12/19 at 1:15 p.m. NA-A confirmed R83 needed staff assistance with toileting, peri cares and recently had C-diff. NA-A indicated R83 was incontinent of bowel at times, and indicated staff were to continue to glove and gown for precautionary measures when the assisted him in the bathroom. NA-A confirmed she did not properly glove and wash her hands while providing incontinent cares for R83 and stated "I should of washed my hands before I left the room." NA-A stated "I knew I should of washed my hands after I did peri cares and took my gloves off." On 6/13/19 at 2:09 p.m. clinical manager (CM)-A confirmed R83 needed staff assistance with toileting, peri cares and recently had C-diff infection. CM-A indicated staff were still gloving and gowning for precautionary measures. CM-A indicated she would expect staff to wash their hands after removing gloves and when going from dirty to clean. The CM-A indicated staff should of washed her hands before she left the room after providing peri cares to prevent the spread of infection and for preventive measure with contamination.	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 41 On 6/13/19 at 2:54 p.m. director of nursing (DON) confirmed she would expect staff to wash their hand after providing peri cares and going from dirty to clean. The DON indicate staff should be following standard precautions. Review of facility policy titled, Hand Hygiene revised on 8/29/18, indicated hand hygiene will be performed by employees at the appropriate times and in the proper manner as described: upon entering or leaving the resident care area, isolation precautions, after contact with patients intact skin, body fluids, or excretions, moving from contaminated body site to clean body site during patient cares and caring for patients with spore- forming agent such as clostridium difficile.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245486	A. BUILDING **01 - 1970 BUILDING** B. WING _____	**06/12/2019**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on June 12, 2019. At the time of this survey, The Perham Living NH was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. The Perham Living NH was constructed at 3 different times. The original building, a 1-story building constructed in 1970 and was determined to be of Type II(000) construction. In 1979, a 1-story with a basement was added to the south west of the original building and was determined to be of Type II(222) construction. However, the building addition is not separated by a 2-hour fire barrier. These 2 buildings were completely renovated in 2006. In 2005 a 2-story building with basement was added to the south west of the 1970 building and was determined to be of Type II(222) construction. In 2016 the east end of the building was remodeled and included a new north entrance. This section is separated by a 2 hour fire barrier. The building is divided into 6 smoke compartments by 30- minute, 1- hour and 2- hour fire barriers. This was surveyed as one building, The facility has a capacity of 96 beds and had a	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245486	A. BUILDING **01 - 1970 BUILDING** B. WING _____	**06/12/2019**

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K 000	Continued From page 1 census of 90 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		