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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: GY8T
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 **08/23/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **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 — Gail Anderson, Unit Supervisor — Date: 09/19/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Joanne Simon, Certification Specialist — Date: 09/19/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **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 **08/24/2017** (L33)

DETERMINATION APPROVAL

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

CMS Certification Number (CCN): 245486 September 18, 2017

Ms. Tracy Hendrickx, Administrator
Perham Living
735 Third Street Southwest
Perham, MN 56573

Dear Ms. Hendrickx:

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 August 29, 2017 the above facility is recommended 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 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
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

Electronically delivered
September 19, 2017

Ms. Tracy Hendrickx, Administrator
Perham Living
735 Third Street Southwest
Perham, MN 56573

RE: Project Number S5486026, F5486026

Dear Ms. Hendrickx:

On August 30, 2017, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective September 29, 2017. (42 CFR 488.417 (b))

Also, we notified you in our letter of August 30, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 29, 2017.

This was based on the deficiencies cited by this Department for a standard survey completed on June 29, 2017, and lack of verification of substantial compliance with the Life Safety Code (LSC) deficiencies at the time of our August 30, 2017 notice. The most serious LSC deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 23, 2017, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 29, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 29, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 29, 2017, as of August 29, 2017.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of August 30, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective September 29, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective September 29, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective September 29, 2017, is to be rescinded.

In our letter of August 30, 2017, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 29, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on August 29, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this PCR 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

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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(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 **06/29/2017** (L34)

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

8. ACCREDITATION STATUS: __ (L10)
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FISCAL YEAR ENDING DATE: (L35) **09/30**

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

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)

12.Total Facility Beds **96** (L18)

13.Total Certified Beds **96** (L17)

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 :
Susan Bachleitner, HFE NEII 08/22/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/24/2017 (L20)

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

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26. TERMINATION ACTION: (L30)
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05-Fail to Meet Health/Safety
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OTHER
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29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **08/24/2017** (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7013 3020 0001 8869 2071

July 14, 2017

Ms. Tracy Hendrickx, Administrator
Perham Living
735 Third Street Southwest
Perham, MN 56573

RE: Project Number S5486026

Dear Ms. Hendrickx:

On June 29, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 8, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 8, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter.

Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the

Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by September 29, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new

admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 29, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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 ______	06/29/2017

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 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident’s records,	F 164		8/8/17

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

Electronically Signed — 08/08/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245486	A. BUILDING ______ B. WING ______	06/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERHAM LIVING	735 THIRD STREET SOUTHWEST PERHAM, MN 56573

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F 164	Continued From page 1 regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure private heath information was not accessible to the public for 1 of 2 residents (R87) reviewed for privacy. Findings include: During morning care observations on 6/28/17 10:12 a.m., R87's room was observed to have three posters with private health information affixed to the bedroom walls, R87 shared a room with another resident in the facility. Directly above the side of R87's bed, there were two, 8 1/2 x 11 inch sheets of white paper affixed to the wall side-by-side. The sheet on the left side included R87's first name and indicated "Resident is NPO(in black letters) Please do not give her	F 164	Signs removed from wall and placed in private area, out of sight of public and staff without a need to know. Facility inspected for additional areas of concern with all potential issues addressed. Staff educated on facility policies and practices related to protection of patient information and privacy. Audits to be completed of resident's room and other identified concerns one time per week for a period of 12 weeks by Neighborhood Coordinator or designee and results will be brought to QAPI to ensure solutions are sustained.	

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 ______	06/29/2017

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
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anything by mouth(in red letters)." The sheet affixed to the wall to the right included R87"s first name and Splint Schedule. "Light Blue Left Hand Splint: On at 8 AM, Off at 9 AM, On at 4 PM, off at 5 PM, on at Midnight, Off at 1 AM. Blue Right Elbow Splint: On 9 AM-11 AM, Off 11 AM-4 PM, On 4 PM-6 PM. Blue Left Elbow Splint: On 1 PM-3 PM, Off 3 PM-8 PM, On 8 PM-10 PM. Darker Blue Right Wrist/hand splint: On at HS, Off during the day." The third 8 1/2 x 11 inch white sheet was affixed on the wall across the room next to R87's television and was the exact same posting as the one by R87's bed, "Resident is NPO(in black letters) Please do not give her anything by mouth(in red letters)."

R87's Care Card dated 6/22/17, which was posted on the inside closet door in a private area, indicated R87 was NPO. The care card directed staff to see splint schedule in room: Elbow splints on right and left arms 2 x/day for two hours. Dark blue resting hand splint on right hand at night. Left hand splint (light blue) on 1 hour 3 times a day.

R87's care plan dated 2/14/17, indicated a sign was placed next to bed indicating NPO status. The care plan did not address the second NPO sign posted in R87's room. The care plan indicated a brace and splint schedule was posted in R87's room.

During interview on 6/28/17, at 10:43 a.m. nursing assistant (NA)-B confirmed R87 did receive visitors, and also shared a room with another resident. R87 indicated each staff member are made aware of each resident's needs by the care card posted on the inside door of each resident's closet. R87 stated if staff still

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	245486	A. BUILDING ______ B. WING ______	06/29/2017

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F 164	Continued From page 3 had questions they were to ask another nursing assistant or nurse if any questions regarding each resident's care could not be answered from the care card. NA-B confirmed all people who entered R87's room could easily see the health information posted, further, NA-B confirmed R87's roommate and their visitors would be able to see the posted health information by R87's bed. NA-B stated the health information was posted more or less for staff reminders of when R87 was to wear her splints. NA-B stated the information had been posted in R87's room for quite some time. During interview on 6/28/17, nursing assistant (NA)-C stated R87 had always been NPO. She indicated the nothing by mouth posters were posted on R87's wall due to change of staff, as some of them needed reminders and or did not know what NPO meant and did not want someone to use water with brushing R87's teeth. NA-C reported the splint schedule changed all the time, and was posted on the wall to remind staff, so staff would not become complacent. NA-C stated the splint wearing schedule should be placed somewhere more private, in a book or somewhere else. NA-C confirmed both visitors for R87 and her roommate would easily be able to see the health information posted by R87's bed. During interview on 6/29/17, at 10:50 a.m., registered nurse (RN)-B confirmed R87 was unable to voice any concerns she may have regarding the private information posted in her room. RN-B stated R87 had an order change to the NPO on 3/14/16, and the NPO sign in R87's room was posted with the change. RN-B confirmed R87's NPO status was identified in	F 164		

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R87's care plan RN-B stated the posting is a reminder for staff, and confirmed staff have been trained what NPO meant. Further, RN-B stated other residents who currently resided in the facility and were NPO status did not have the information posted on their bedroom wall for staff reminders. RN-B confirmed R87 did not have any events in the past where fluids or foods were given, and stated the sign was posted due to an order change over a year ago, and precautionary measures. RN-B reported R87's splint scheduled changed frequently, and staff did not have a way for the nursing assistant to see the information so they decided to post it on her wall. RN-B confirmed R87 shared a room with another resident, and confirmed both R87 and her roommate frequently had visitors in their room. RN-B verified the information posted on R87's wall would be visible to all visitors that entered the room. RN-B stated R87's splint schedule should be in her closet where the care card was located, and stated it was a more private location and was where stuff is posted to keep private. RN-B verified it is not usual protocol to post private health information in resident rooms, and stated all of the information can be on R87's care card and should be.

During interview on 6/29/17, at 3:13 p.m., the director of nursing (DON) stated she felt it was appropriate to have the information posted in visible areas and would be hesitant to post the information regarding to have nothing by mouth in a private place. The DON stated she felt the sling schedule should not be posted in R87's room, and would expect the schedule to be kept private and should go inside of the closet.

The facility's Privacy Policy dated 12/2013,

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F 164	Continued From page 5 directed staff to protect privacy of medical records and other personal health information of its patients without jeopardizing patients access to health care or the quality of their health care. directed to only allow parties with legitimate interests to access confidential information.	F 164		
F 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may	F 166		8/8/17

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be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident’s grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident’s concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be

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F 166	Continued From page 7 taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to to act on a concern for 1 of 1 resident (R54) who expressed a concern to facility staff about receiving respectful and timely assistance with a meal. Findings include: R54's significant change Minimum Data Set (MDS) dated 4/12/17, indicated the resident had intact cognition. The MDS also indicated R54 was able to express her ideas and wants and made herself understood. During an interview on 6/26/2017, at 12:40 p.m. R54 reported on 6/22/17, at 10:00 a.m. that he had received no breakfast. R54 indicated he filed a grievance with the director of nursing on 6/22/17, then reported no one had followed up with him since. R54 stated he entered the dining room on 6/22/17 around 10:00 a.m., a dietary	F 166	Employee involved in R54s grievance received additional education regarding working with R54, customer service, and facility grievance policy. Concern was discussed with R54 and documented on facility grievance form. Other residents with potential to be impacted identified through staff education and procedure to notify administrator or designee as soon as reasonably possible when a resident complaint arises. Facility will act to resolve all grievances in the time period indicated by facility policy. All employees educated on facility grievance policy. Grievances will be audited for 12 weeks by Director of Social Services or designee and audits will be reviewed at QAPI to ensure solutions are sustained.	

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staff (dietary aide (DA-A) was working in the kitchen and ignored him two times, and did not serve him breakfast. R54 stated at 11:00 a.m. a nurse (licensed practical nurse (LPN)-B), asked him if he had eaten breakfast, he told the nurse no, and not to let DA-A lie to her. R54 reported DA-A told LPN-B there was no food left. R54 stated LPN-B did offer to make him toast or something, and he declined and stated he would just wait for lunch. R54 reported on 9/17/16, DA-A had ignored him in the dining room, pretended she did not see him and did not serve him the meal. R54 verified LPN-B did end up making him toast that time. R54 stated he reported the incident on 9/17/16 to DA-A's supervisor, then stated, this is a pattern of DA-A to bully us with the rule. During follow up interview with R54 on 6/26/17, at 12:47 p.m. and 6/28/17, at 2:55 p.m. R54 confirmed no staff person had followed up with him regarding the grievance filed on 6/22/17.

Review R54's nurses notes from 6/22/17 to 6/29/17 failed to identify the concern which occurred on 6/22/17.

On 6/29/17, at 10:17 a.m. grievances filed with the facility in the past six months were reviewed. There was no grievance or documentation regarding R54's concern which occurred on 6/22/17. The director of nursing (DON) verified there was only one grievance filed in the past six months.

During interview on 6/29/17, at 10:56 a.m. registered nurse (RN)-B stated she heard of R54's incident on 6/22/17. RN-B stated R54 was very aware of the open door policy that residents can come and talk to her or the household

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coordinator about anything. RN-B reported she heard R54 had an issue with DA-A in the kitchen. R54 had a bath, and by the time he got to the kitchen he did not get served breakfast. RN-B reported R54 did not report this to any of the registered nurses or the household coordinators, and stated he went straight down and filed a complaint with the DON. RN-B reported R54 had a history of behaviors of targeting different staff members, and stated the ombudsman, social services, DON, and administrator had been involved with different situations and different staff members. RN-B reported there used to be a different staff member that used to work on R54's unit, and now that staff person works on a different unit, and once one thing is resolved, R54 moves on to another thing. RN-B confirmed R54 had intact cognition and was reasonable. RN-B was not sure if anyone followed up with him regarding the incident on 6/22/17 or how the DON followed up with him about it. RN-B was not aware of any other instances regarding R54 and DA-A.

During interview on 6/29/17, at 12:32 p.m. LPN-B confirmed she was aware of the incident on 6/22/17. LPN-B reported R54 had not slept well the night before, had slept in, received a bath and got to the dining room for breakfast around 10:30 a.m. LPN-B asked R54 around 11:00 a.m. if he had breakfast yet, and he told her no I did not get any, DA-A ignored me. LPN-B reported at that time she went into the kitchen and spoke with DA-A. LPN-B stated DA-A told her she took the rest of the food down and was not available. LPN-B confirmed there is always food in the kitchen area, and stated she offered to get R54 breakfast, but R54 declined and stated he would wait for lunch because it was chipped beef on

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noodles.

During interview on 6/29/17, at 2:25 p.m., the director of social services (DSS) confirmed the facility had not received any formal complaints or grievances from R54, and verified the facility only had one grievance filed in the past year. The SSD confirmed she was the person who was responsible to manage all grievance reports. The SSD reported she felt there were ongoing issues with R54, and the facility had an open door policy with him. The SSD stated she felt R54 shared concerns with management staff and nursing if something happened. The SSD reported she had set up a meeting with R54 and the ombudsman regarding concerns. The SSD stated she was aware of the facility policy in regards to the timeframe to follow up with a resident or family member once a concern or complaint had been submitted.

During interview on 6/29/17, at 3:16 p.m. the DON confirmed she had met with R54 on 6/22/17 and wrote down his concerns regarding the incident in the dining room with DA-A, and stated she told him she would follow up with him. The DON confirmed she had not yet followed up with R54 regarding his complaint. The DON confirmed R54 did tell her DA-A had ignored him on another occasion. The DON stated DA-A's supervisor had already known about the incident, and thought staff had told her about it. The DON stated staff offered to make R54 food and he declined the food, then stated R54 had come back after visiting with her and turned the initial incident into another story. The DON stated R54 stated he wanted to talk about something that nobody had done anything about yet. The DON stated DA-A's supervisor had spoken to DA-A

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about this incident. DON stated no other residents had complaints with this staff person, and stated she felt R54's behaviors of being demanding and disrespectful were the root of the complaints and concerns. The DON stated she only had contact with R54 a few times in the past and could not provide any documentation of the grievance filed by R54 or the follow-up and investigation of the complaint. The DON stated she felt this compliant voiced by R54 was an ongoing issue and not a new concern was the reason a formal grievance was not filed. The DON stated she did not start any official documentation of the grievance and wanted to know what the director of nutritional services (DNS) and the SSD had done before with R54. The DON stated the ombudsman had come in to help resolve concerns regarding R54, but had not been in to visit regarding the incident on 6/22/17.

During interview on 6/29/17, at 3:32 p.m. the DNS confirmed the DON called her and informed her of R54's complaint on 6/22/17. The DNS reported DA-A denied any instances of ignoring or exchanging words with R54. The DNS confirmed there had been prior allegation by R54 against DA-A of ignoring him in the past, in the past DA-A had apologized to R54. DNS confirmed DA-A had also received personal education regarding dignity and customer service within the past year. The DNS confirmed she had not yet followed up with R54 regarding the incident on 6/22/17.

The facility's Grievance Complaint Facility Wide policy dated 6/6/17, indicated all resident complaints, verbal or written, will be managed so that the concerns person(s) is treated with the highest level of integrity and fairness possible. A written complaint is always considered a

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F 166	Continued From page 12 grievance, and in all cases, a written response shall be provided to the patient/representative. If a response and investigation cannot be completed within 7 days, staff will document and inform the patient that the hospital is working to resolve the grievance and will follow-up with a written response within 30 days of date of the grievance was initiated.	F 166		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect,	F 225		8/8/17

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F 225	Continued From page 13 exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report, no later than 2 hours after knowledge of the fractured clavicle the previous day to the administrator and to the	F 225	Resident fall reported and investigation completed. Fall interventions in place with intent to prevent future falls with injury. Fall reporting procedures changed to	

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State Agency (SA) for 1 of 1 resident (R36) with an injury of unknown origin.

Findings Include:

R36's quarterly Minimum Data Set (MDS) dated 5/12/17, identified R36 had diagnoses which included Alzheimer's disease, heart failure and Diabetes Mellitus. The MDS identified R136 had severe cognitive impairment, hallucinations and delirium with disorganized thinking and inattention. Further, the MDS identified R136 required extensive assistance from staff with all activities of daily living (ADL's) and ambulation.

R36's care plan, revised 6/9/17, identified R36 had dementia, psychosis, had hallucinations and delusions, and was unaware of safety needs. R36's care plan listed various interventions which included the use of task segmentation for short term memory deficits, utilized a mechanical lift and required extensive assistance of staff for transfers, grooming, bathing and toileting.

Review of R36's progress notes from 6/3/17 to 6/4/17, revealed on 6/3/17, at 11:00 p.m. R36 was found on the floor in a kitchenette of the facility and was indicated R36 had a unwitnessed fall. The progress notes identified the following:

-6/3/17, at 11:00 p.m. LPN heard a sound from kitchen and found resident in semi-sitting position, leaning to his left on an overturned walker. The front right wheel of the walker was loose and walker was unsafe for use. The note identified R36's fall was unwitnessed and R36 reported discomfort of upper right chest area over clavicle, with soft tissue swelling. R36 reported some discomfort when he raised his right arm

Provider's Plan of Correction (F 225):

increase communication and dialogue following resident falls.
Facility staff educated on VA policies, procedures, and timely reporting. Policies updated to provide improved guidance in decision making and identification of reportable events and reporting times per new regulations. All potential incidents of vulnerable adult abuse will be reported to administrator immediately and OHFC within mandated time period.
Falls Committee will review falls at regular meetings to ensure appropriate action. Social Services Director or designee will audit VA reports as they occur for 12 weeks for appropriateness and timeliness and will review at QAPI to ensure solutions are sustained. Corrective action will be completed by August 8, 2017.

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	245486	A. BUILDING ______ B. WING ______	06/29/2017

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PERHAM LIVING	**735 THIRD STREET SOUTHWEST PERHAM, MN 56573**

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F 225	Continued From page 15	F 225		

and may need to be sent to the ER for evaluation of the am. The note lacked documentation of the administrator or director of nursing (DON) had been notified, and listed a vulnerable adult report was not needed. The note further indicated R36 was in his wheelchair in his room minutes before. The note indicated R36 could not lift his right arm very high without it hurting by his collar bone and ice packs were applied on his right side of neck where the area was puffy. R36 told staff he was going for a walk. R36 had been walking independently.

-6/4/17, 10:38 a.m. R36 complained of right shoulder pain and no active range of motion at the joint and R36 was sent to the Perham Health Emergency Department (PHED). At 4:02 p.m. R36 had returned from the emergency department with a diagnosis of fractured clavicle on his right side by his sternum.

No further documentation indicated the administrator or SA were notified of R36's unwitnessed fall with serious injury.

The facility incident report titled, "Post Fall Safety Report" dated 6/3/17, at 10:15 p.m. indicated R36 had an unwitnessed fall and was found lying on his left side in the dining/kitchenette area. The report further indicated R36 may need an x-ray of his right clavicle area in the a.m. The report instructions indicated immediate notification to administrator, DON, and director of Quality for any major injuries, which included bone fractures, or death. The report lacked documentation the administrator had been immediately notified of R36's unwitnessed fall with possible injury to right clavicle. Also, the report lacked documentation of the investigation of when the wheel of walker

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F 225	Continued From page 16	F 225		

broke, prior to or after fall.

The facility form titled "Perham Living Interdisciplinary Falls Weekly Tracking Log, dated 6/8/17, indicated R36 was delusional. When staff left he got up on his own using walker. Wheel on walker bent, not sure if he fell and then walker broke or if wheel broke and he fell.

The incident report, numbered 301840, was submitted to the Office of Health Facility Complaints (OHFC) on 6/5/17, at 4:34 p.m. The report indicated an incident that resulted in a serious injury to the R36. The injury was described as a non-displaced fracture of the sternal end of right clavicle.

On 6/28/17, at 2:41 p.m. the registered nurse clinical manager (CM)-A verified the progress note dated 6/4/17 and the discharge instructions from PHED dated 6/4/17, signed by RN-E indicated R36 returned from PHED with a clavicle fracture on 6/4/17, at 4:02 p.m. CM-A indicated she did not know if a SA report was submitted and confirmed she did not submit a report. CM-A indicated she was not sure when to submit SA reports, but indicated she was instructed that when in doubt to just file a report. CM-A indicated the administrator had emphasized that they should just submit a report to the SA if unsure or contact the administrator who would then help the staff decide.

On 6/29/17, at 9:14 a.m. the DON and surveyor reviewed together R36's progress notes from 6/3/17 to 6/5/17, the PHED discharge instructions from 6/4/17, the Post Fall Safety Report dated 6/3/17 and the SA report submitted 6/5/17. The DON confirmed she became aware of the

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F 225	Continued From page 17	F 225		

incident on Monday 6/5/17 and at that time she inquired if a SA report had been submitted. DON t indicated one had not been submitted, so the facility submitted one on 6/5/17. DON confirmed the SA report was submitted late. DON indicated some staff had the misconception that if the facility was following the care plan a SA report did not need to be filed.

On 6/29/17, at 12:38 p.m. the administrator confirmed she had not been informed of R36's fall or fracture until Monday, 6/5/17 and had not been notified when R36's fracture had been confirmed. The administrator confirmed the facility's current policy and she indicated the facility would not have reported the incident if the facility followed their facility policy algorithm and the facility was following R36's care plan and the staff felt they knew how the injury occurred. The adminstrator indicated the facility had filed the SA report on Monday on 6/5/17 because the facility questioned if R36 should have been sent to PHED right away the night of the fall.

Review of the facility policy titled, Mandated Reporting VA NH Swing Bed, revised 6/6/17, identified staff must report any incidents of actual or suspected maltreatment to the Office of Health Facility Complaints (OHFC) immediately* upon becoming knowledgeable of the incident. Actual or Suspected Maltreatment included; injuries that did not have a witness, or cannot be explained; i.e. injury is suspicious due to the extent or location, unexplained bruising, etc. Falls included those that resulted in major injury with care plan not followed, major injuries included; bone fractures. An injury should be classified as an Injury of unknown source when both the following conditions are met; the source of the injury was

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F 225	Continued From page 18 not observed by any person or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observe at one particular point in time or the incidence of injuries over time. The policy instructed staff to contact the nursing home administrator prior to making the report. The facility policy titled, Mandated Reporting VA NH Swing Bed, revised 6/6/17, provided by the administrator, identified that staff must report incidents of injuries of unknown source, however the facility policy had not been updated to include that the report was required no later than two hours after the knowledge of the serious injury.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to	F 226		8/8/17

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F 226	Continued From page 19 the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement the facility abuse prohibition policy for injuries of unknown origin to immediately report to the administrator and immediately report to the State Agency (SA) for 1 of 1 residents (R36) who sustained a fractured clavicle after an injury of unknown origin. Findings Include: Review of the facility policy, provided by the administrator, titled Mandated Reporting VA NH Swing Bed, revised 6/6/17 identified staff must report any incidents of actual or suspected maltreatment to the Office of Health Facility Complaints (OHFC) immediately* upon becoming knowledgeable of the incident. Actual or Suspected Maltreatment included; injuries that did not have a witness, or cannot be explained; i.e. injury is suspicious due to the extent or location, unexplained bruising, etc. An injury should be classified as an Injury of unknown	F 226	Resident fall reported and investigation completed. Fall interventions in place with intent to prevent future falls with injury. Facility reporting procedures changed to increase communication and dialogue following resident falls. Facility staff educated on VA policies, procedures, and timely reporting. Policies updated to provide improved guidance in decision making and identification of reportable events and reporting times per new regulations. All potential incidents of vulnerable adult abuse will be reported to administrator immediately and OHFC within mandated time period. Social Services Director or designee will audit VA reports as they occur for 12 weeks for appropriateness and timeliness and will review at QAPI to ensure solutions are sustained.	

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F 226	Continued From page 20	F 226		

source when both the following conditions are met; the source of the injury was not observed by any person or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observe at one particular point in time or the incidence of injuries over time. The policy instructed staff to contact the nursing home administrator prior to making the report. However, the facility policy had not been updated to include the report was required no later than two hours after the knowledge of the serious injury.

R36's quarterly Minimum Data Set (MDS) dated 5/12/17, identified R36 had diagnoses which included Alzheimer's disease, heart failure and Diabetes Mellitus. The MDS identified R136 had severe cognitive impairment, hallucinations and delirium with disorganized thinking and inattention. Further, the MDS identified R136 required extensive assistance from staff with all activities of daily living (ADL's) and ambulation.

R36's care plan, revised 6/9/17, identified R36 had dementia, psychosis, had hallucinations and delusions, and was unaware of safety needs. R36's care plan listed various interventions which included the use of task segmentation for short term memory deficits, utilized a mechanical lift and required extensive assistance of staff for transfers, grooming, bathing and toileting.

Review of R36's progress notes from 6/3/17 to 6/4/17, revealed on 6/3/17, at 11:00 p.m. R36 was found on the floor in a kitchenette of the facility and was indicated R36 had a unwitnessed fall.

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F 226	Continued From page 21	F 226		

The progress notes identified the following:

-6/3/17, at 11:00 p.m. LPN heard a sound from kitchen and found resident in semi-sitting position, leaning to his left on an overturned walker. The front right wheel of the walker was loose and walker was unsafe for use. The note identified R36's fall was unwitnessed and R36 reported discomfort of upper right chest area over clavicle, with soft tissue swelling. R36 reported some discomfort when he raised his right arm and may need to be sent to the ER for evaluation of the am. The note lacked documentation of the administrator or director of nursing (DON) had been notified, and listed a vulnerable adult report was not needed. Documentation further indicated R36 was in his wheelchair in his room minutes before. The note indicated R36 could not lift his right arm very high without it hurting by his collar bone and ice packs were applied on his right side of neck where the area was puffy. R36 told staff he was going for a walk. R36 had been walking independently.

-6/4/17, 10:38 a.m. R36 complained of right shoulder pain and no active range of motion at the joint and R36 was sent to the Perham Health Emergency Department (PHED). At 4:02 p.m. R36 had returned from the emergency department with a diagnosis of fractured clavicle on his right side by his sternum.

No further documentation indicated the administrator or SA were notified of R36's fall with serious injury.

The facility incident report titled, "Post Fall Safety Report" dated 6/3/17, at 10:15 p.m. indicated R36 had an unwitnessed fall and was found lying on

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F 226	Continued From page 22	F 226		

his left side in the dining/kitchenette area. The report further indicated R36 may need an x-ray of his right clavicle area in the a.m. The report instructions indicated immediate notification to administrator, DON, and director of Quality for any major injuries, which included bone fractures, or death. The report lacked documentation the administrator had been immediately notified of R36's unwitnessed fall with possible injury to right clavicle. Also, the report lacked documentation of the investigation of when the wheel of walker broke, prior to or after fall.

The facility form titled "Perham Living Interdisciplinary Falls Weekly Tracking Log, dated 6/8/17, indicated R36 was delusional. When staff left he got up on his own using walker. Wheel on walker bent, not sure if he fell and then walker broke or if wheel broke and he fell.

The incident report, numbered 301840, was submitted to the Office of Health Facility Complaints (OHFC) on 6/5/17, at 4:34 p.m. The report indicated an incident that resulted in a serious injury to the R36. The injury was described as a non-displaced fracture of the sternal end of right clavicle.

On 6/28/17, at 2:41 p.m. the registered nurse clinical manager (CM)-A verified the progress note dated 6/4/17 and the discharge instructions from PHED dated 6/4/17, signed by RN-E indicated R36 returned from PHED with a clavicle fracture on 6/4/17, at 4:02 p.m. CM-A indicated she did not know if a SA report was submitted and confirmed she did not submit a report. CM-A indicated she was not sure when to submit SA reports, but indicated she was instructed that when in doubt to just file a report. CM-A indicated

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F 226	Continued From page 23 the administrator had emphasized that they should just submit a report to the SA if unsure or contact the administrator who would then help the staff decide. On 6/29/17, at 9:14 a.m. the DON and surveyor reviewed together R36's progress notes from 6/3/17 to 6/5/17, the PHED discharge instructions from 6/4/17, the Post Fall Safety Report dated 6/3/17 and the SA report submitted 6/5/17. The DON confirmed she became aware of the incident on Monday 6/5/17 and at that time she inquired if a SA report had been submitted. DON t indicated one had not been submitted, so the facility submitted one on 6/5/17. DON confirmed the SA report was submitted late. DON indicated some staff had the misconception that if the facility was following the care plan a SA report did not need to be filed. On 6/29/17, at 12:38 p.m. the administrator confirmed the current facility policy and confirmed she had not been informed of R36's fall or fracture until Monday, 6/5/17 and had not been notified when R36's fracture had been diagnosed. The administrator indicated the facility would not have reported the incident if the facility followed their facility policy algorithm and the facility was following R36's care plan and the staff felt they knew how the injury occurred. The adminstrator indicated the facility had filed the SA report on Monday on 6/5/17 because the facility questioned if R36 should have been sent to PHED right away the night of the fall.	F 226		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each	F 241		8/8/17

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F 241	Continued From page 24 resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure residents were provided grooming services related to long facial hair for 1 of 1 residents (R82) reviewed for dignity concerns. Findings include: R82's quarterly MDS dated 4/5/17, identified R82 had diagnoses which included Alzheimer's disease, and Parkinsons disease. The MDS identified R82 had moderate cognitive impairment, and required extensive assistance of one staff for activities of daily living (ADL's) except limited assistance for dressing and personal hygiene. R82's care plan, revised on 3/21/17, identified R82 had ADL self care performance deficit related to weakness and de-conditioning. R82's care plan indicated R82 required staff assistance of one for bathing of lower body, back, hair and directed staff to give cues and encouragement for R82 to complete her upper body. Review of the Perham Living Care Card undated, identified R82 needed extensive assistance of one staff to set up for grooming needs and bathing occurred on Wednesdays in the a.m. Review of the Burlington Bath Schedule undated, indicated R82 receives her bath on Tuesdays in	F 241	Resident affected provided with new razor and with limited assistance as needed. Other residents affected identified through ongoing monitoring of resident personal hygiene for residents independent or requiring limited assistance in cares. All facility staff educated on resident right to dignity and respect of individuality and the need to continuously monitor resident success in self-care. Audits will be completed by Neighborhood Coordinator or designee to monitor residents in self-care to ensure appropriate hygiene is maintained one time per week for 12 weeks with results reviewed at QAPI to ensure solutions are sustained.	

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F 241	Continued From page 25 the a.m. The bath schedule further indicated in big bold letters for staff to "DO NOT FORGET NAILS, SHAVING AND VITALS." During observations on 6/26/17 at 10:54 a.m. R82 was in her room, sitting in her wheelchair and was noted to have several long, thick black/white facial hairs on her chin area. R82 continued to have several long, thick black/white facial hairs on her lower chin area all day. During observation on 6/27/17 at 2:19 p.m. was in the seated in her wheelchair in the town center and was actively playing bingo with many other residents and visitors. R82 continued to have several long, thick black/white facial hairs on her lower chin area at 7:32 p.m., when she was noted wheeling herself out of the bathroom to her room. During observation on 6/28/17 at 9:10 a.m. R82 was seated in her wheelchair in the bathroom attempting to perform oral cares and put her dentures in. R82 continued to have several long, thick black/white facial hairs on her lower chin area. At 10:34 a.m. NA-A briefly entered the bathroom, and exited the bathroom, and did not offer to assist R82 to remove the long facial hair. At 10:36 a.m. licensed practical nurse (LPN)-A entered the bathroom, visualized R82's mouth, prepared a mouth rinse for R82. At 10:45 a.m. LPN-A left the room briefly, re-entered the room and assisted resident to put dentures in mouth and took her out to the dining room area for brunch at 10:55 a.m. R82 continued to have several long, thick black/white facial hairs on her lower chin area and was not provided assistance by NA-A and LPN-A. During observation on 6/29/17 at 9:45 a.m. R82	F 241		

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F 241	Continued From page 26	F 241		

was seated in her wheelchair in her room and was noted to have several long, thick black/white facial hairs on her chin area.

On 6/27/17 at 7:35 a.m. R82 indicated she had broken her razor and threw it away. R82 indicated she does not like having the long hairs on her chin area and stated "I like them off, they are so long on my chin, they make me feel bad." R82 indicated she did not want to ask anyone to buy her a new razor because she could not afford a new one and stated " I don't like to bother anyone."

On 6/29/17 at 9:38 a.m. NA-A verified bath schedule and indicated R82 had been more independent with cares in the past but needed more help lately. NA-A indicated R82 needs assistance with shaving and staff was to shave R82 on her bath days and in-between if needed.

On 6/29/17 at 9:49 a.m. LPN-A confirmed the facility bath schedule and indicated R82 had been more independent with cares in the past but has needed more help recently, depending on the day. LPN-A indicated R82 had shaved herself in the past but had not been doing it and stated "I don't know why." LPN-A indicated staff were supposed to shave residents on their scheduled bath days and as needed. LPN-A indicated R82 did have cognitive issues at times and she was not aware R82's razor was broken or that the facial hair bothered R82. LPN-A indicated her expectations of staff would be to help R82 with this and stated "making sure she is getting shaved on her bath day."

On 6/29/17 at 10:34 a.m. director of nursing (DON) confirmed staff should be assisting

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	245486	A. BUILDING ______ B. WING ______	06/29/2017

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 241	Continued From page 27 resident with facial hair and she would expect staff help any resident on a daily basis to shave and stated "staff should be helping the residents with cares." The DON indicated she felt this was a dignity issue for the resident. The DON also indicated she would expect staff to know if resident equipment was in good working order and stated "we always have new razors on hand to use for residents." The DON indicated she would further expect staff to make sure R82 has what she needs. Review of facility policy titled Bill of Rights and Responsibilities revised on 6/6/17, indicated it is the policy of Perham Health to support and care for all patients in a manner and in an environment that promotes quality of life with emphasis placed on dignity, choice and self determination	F 241		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed	F 356		8/8/17

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F 356	Continued From page 28 vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the required nursing staff posting information included the correct daily posting, census and staff working in the facility. This had the potential to affect all 87 current residents and any visitors in the facility. Findings include:	F 356	Nurse staffing posting updated daily and upon changes in staffing. Staff education to ensure staffing information is updated and accurate. Back-up plans in place to accommodate absence of receptionist to include weekends and holidays. Facility process developed to include daily updates.	

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F 356	Continued From page 29 During the initial tour on 6/26/17 at 6:45 a.m. the nursing hours posting was observed in a clear plastic sleeve, seated on the receptionist desk at the entrance of the facility. The posting dated 6/23/17, included the required nurse hours and categories, however, the posting was dated 6/23/17, and resident census of 88 and the nursing staff was not updated to reflect the accurate number of long term care registered nurse care coordinators (LTC RNCC) for the 7:30 a.m. to 4:00 p.m. shift. On 6/26/17 at approximately 10:00 a.m. the staff posting was changed to reflect the current date of 6/26/17, however, the nursing staff was not updated to reflect the accurate number of LTC RNCC for the 7:30 a.m. to 4:00 p.m. shift. On 6/26/17 at 7:00 a.m. registered nurse (RN)-A confirmed the nurse staff postings were inaccurate. RN-A indicated the staff posting was only changed Monday through Friday when the receptionist worked and stated "we don't update it on the weekends." RN-A indicated the receptionist updated the staff postings on Monday when she comes to work and was not sure if the staff postings get updated to reflect daily staffing or census in the facility and verified nursing staff was not responsible for updating staff postings on the weekends. On 6/26/17 at 2:32 p.m. receptionist confirmed she was responsible for the staff posting Monday through Friday and had a back up receptionist who completed this during the week when she was not at the facility. The receptionist confirmed the staff posting did not get updated on the weekends. The receptionist indicated she would update the staff postings to reflect accurate	F 356	Staffing posting will be audited by Assistant Director of Nursing or designee for compliance one time per week for 12 weeks and results will be reviewed at QAPI to ensure solutions are sustained.	

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F 356	Continued From page 30 information during the week days if she was aware the census or staffing had changed otherwise it did not get updated. On 6/29/17 at 10:41 a.m. director of nursing (DON) confirmed the staff posting should be changed and updated daily. The DON indicated the charge RN on the weekends was responsible for changing the staff posting out daily, but not updating the staff posting and making changes to reflect accuracy of staffing and census. On 6/27/17 requested policy for staff posting, one was not provided.	F 356		
F 372 SS=D	483.60(i)(4) DISPOSE GARBAGE & REFUSE PROPERLY (i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure proper containment of garbage in the outside dumpster to prevent attracting pests and rodents. This had the potential to affect all 87 residents residing at the facility. Findings include: On 6/26/17, at 7:08 a.m. a tour of the kitchen was conducted with the food services director (FSD). The tour included an observation of the garbage dumpster area outside of the facility. The dumpster was utilized for kitchen and other nursing home waste. The dumpster was observed to have white colored garbage bags piled high in the dumpster with the lid of the dumpster unable to close. On the ground at the base of the dumpster were six large white	F 372	Additional dumpsters added to facility grounds to increase capacity and allow for appropriate refuse storage and removal. This concern will remain a performance improvement project until compliance is verified. Employees educated on appropriate refuse removal practices and actions to take in the event that the dumpsters do become full. Dumpster areas will be monitored for cleanliness on a daily basis by Maintenance Director or designee with audits completed for a period of 12 weeks and reviewed at QAPI.	8/8/17

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F 372	Continued From page 31	F 372		

garbage bags and two pieces of card board approximately five to six feet square.

On 6/26/17, at 7:08 a.m. the FSD verified these findings and indicated the dumpster was overflowing with trash bags because the garbage service emptied the dumpster daily during the week but not on the weekends.

On 6/27/2017, at 2:25 p.m. the garbage dumpster was observed piled high with white bags and the lid unable to close.

On 6/28/2017, at 9:06 a.m. the garbage dumpster was observed with the director of nutritional services (DNS). The dumpster was again piled high with large white garbage bags.

On 6/28/2017, at 9:06 a.m. the DNS verified the garbage dumpster was again piled high with garbage bags and indicated the dumpster was emptied on Monday but was not sure when it would be emptied again. The DNS indicated the facility had recently removed a dumpster from this area and moved it to another side of the building. The DNS indicated the maintenance department was aware of the garbage dumpster problems and was working on a solution.

On 6/29/2017, at 9:07 A.M. the environmental services director (ESM) verified being aware of the facility garbage management problem. The ESM indicated an entry to the building was added two months ago and in order to make the garbage dumpster more centrally located, one of the dumpsters by the kitchen area had been moved to an area closer to the new entry. The ESM indicated this past weekend was the first

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F 372	Continued From page 32 time with one dumpster in this area, no garbage removal over the weekend, and an overflowing dumpster. On 6/29/2017, at 9:19 A.M. nursing assistant (NA)-G identified the facility had made recent changes to garbage removal. NA-G identified the maintenance staff removed the garbage from the facility and now the floor staff take the bags out to the dumpsters. On 6/29/2017, at 9:30 A.M. trained medical assistant (TMA)-D verified changes in trash removal from the building. TMA-D indicated staff previously would place the garbage bags in a receptacle and then the maintenance staff would take it out to the dumpsters. TMA-D indicated approximately two weeks ago floor staff began take the garbage out to the dumpsters and yesterday a memo came out with information of when specific dumpsters are emptied. On 6/29/2017, at 2:17 P.M. the DNS verified the facility staff had placed garbage bags on the ground around the full dumpster. The DNS indicated staff should have placed the garbage bags in another dumpster and not on the ground. On 6/29/2017, at 3:49 P.M. the director of nursing (DON) verified the facility had recently made changes in management of the facility garbage but would expect the garbage to be contained and not on the ground. A requested garbage handling facility policy was not provided.	F 372		

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F 441	Continued From page 33	F 441		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (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:	F 441		8/8/17

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F 441	Continued From page 34 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure soiled laundry was handled in a manner to prevent the spread of infection through cross contamination. This practice had the potential to affect all 87 residents currently residing in the facility, who had laundry or linens processed in the facilities laundry department. In addition, the facility failed to ensure appropriate infection control measures were properly maintained while storing ice packs	F 441	Laundry employees immediately began utilizing PPE when handling soiled linen. Ice packs removed from freezer immediately and a separate purchase for storage of ice pack and currently in use. Employees educated on policy for policies for handling soiled linen and storage of ice packs. Compliance audited by Housekeeping and Laundry Supervisor or designee one time	

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F 441 Continued From page 35

with ready to eat foods in 1 of 5 kitchenettes.

Findings include:

During tour of the laundry area on 6/29/17 at 8:40 a.m. housekeeping aid (HA)-A stood in the soiled laundry area in front of a front loading washing machine with a large yellow hamper lined with a plastic covering, full of soiled linen. HA-A wore gloves on both of hands as she proceeded to bend over the yellow hamper, while grabbing soiled linen with both hands from the yellow hamper and placing items in the front load washer repeatedly until the yellow hamper was empty. HA-A wore a scrub style uniform which touched the side of the soiled yellow hamper and soiled linen while she repeatedly grabbed the soiled linen items from the yellow hamper to put into the washer. HA-A proceeded to shut the door to the washer, move the yellow hamper in the back of the soiled laundry area, remove her gloves and started the washing machine.

On 6/29/17 at 8:43 a.m. HA-A confirmed she routinely worked in the laundry department. HA-A indicated the various households brought the soiled laundry down in plastic bags and placed them in the hampers in the soiled laundry area. HA-A indicated staff would wear gloves and gown, remove the soiled linen out of the plastic bags, sort into separate bins such as: whites, colors and wash temperatures. HA-A also indicated after the soiled linen sorted, staff would take the soiled linen over to the washer and load the washer while still wearing their gloves and gown.
HA-A confirmed she had not worn a gown when she was handling soiled linen while loading the washing machine and stated staff were expected

F 441

per week for 12 weeks with results reviewed at QAPI to ensure solutions are sustained. Household Coordinator or designee will audit for appropriate ice pack storage in the household one time per week for a period of 12 weeks to ensure solutions are sustained. Results will be reviewed at QAPI.

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F 441	Continued From page 36 to always wear aprons and gloves when handling dirty laundry. In follow up interview at 8:50 a.m., HA-A indicated she works in both the dirty area and the clean area during her shift. HA-A also indicated the facility was short staffed today and staff were in a hurry. On 6/29/17 at 9:18 a.m. environmental service manager (ESM) confirmed staff have protective equipment to wear when handling yellow bag items but was not sure if staff should be wearing protective equipment while sorting and handling soiled linen. After review of the facility policy, EMS stated "they should probably be in personal protective equipment (PPE) when handling dirty linen." The ESM indicated his expectation of staff would to wear (PPE) when handling dirty linen and working with it to minimize cross contamination that could occur. Review of the facility policy titled, Infection Control in Laundry, reviewed on 2/16, indicated the use of personal protective equipment such as gloves and gowns should be used when sorting soiled linen in laundry even when it is not obviously contaminated with blood/body fluids. Ice packs were stored with ready to eat foods in 1	F 441		

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of 5 kitchenettes.

During dining observation on 6/26/17, at 12:33 p.m. the refrigerator in the kitchenette in Prairie Knoll neighborhood was noted to have eight blue re-usable ice packs located on the top shelf and two shelves in the door of the freezer. Two blue re-usable ice packs were laying directly in front of ready to eat individual ice cream cups and an opened bag containing 6 English muffins on the top freezer shelf. Three blue re-usable ice packs were in the middle door shelf and three re-usable ice packs wrapped in plastic were on the bottom door shelf. Other food items; including bagels, donuts, ready to eat individual ice cream cups and a container of muffins were located in the freezer on shelves directly across from the door shelves containing the ice packs.

On 6/26/17, at 12:48 p.m. registered nurse (RN)-C visualized the Prairie Knoll neighborhood freezer and confirmed the above findings. RN-C indicated she had not been aware of the re-usable ice packs being stored in the freezer with ready to eat foods. RN-C immediately removed the ice packs from the freezer and placed the ice packs in a small white compact freezer which sat on a small table in the private dining room area. RN-C then placed the ice packs in the compact freezer and indicated the ice packs were to be stored in this freezer only. RN-C indicated she would expect staff to store the re-usable ice packs in the correct freezer and not where food is stored. RN-C indicated in the past, the facility had utilized the medication room refrigerator/freezer to store re-useable ice packs, but in the last few weeks had implemented the use of the white compact freezer for ice packs.

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On 6/26/17, at 1:27 p.m. trained medication aid (TMA)-A confirmed the re-usable ice packs were used on a resident body when a resident in the facility had a nose bleed, injury or inflammation. TMA-B also indicated they used a sleeve kept in the resident's room to cover the ice packs when they used them on resident (R)36 for inflammation that resulted from a fracture. TMA -A indicated R36 used the ice packs daily and she indicated she cleaned the ice packs after use with sanitization wipes.

On 6/29/2017, at 9:04 a.m. director of nursing (DON) indicated all households had new freezers dedicated just for ice pack storage to assure they were not stored with food. DON indicated prior to the new freezers the ice packs had been stored in the medication refrigerator freezers in the medication rooms. DON indicated the facility policy was to not store ice packs with food. DON verified ice packs and ready to eat foods should not be stored together for infection control management. DON confirmed the facility had a procedure for proper ice pack storage but their procedure was not followed.

On 6/29/17, a facility policy on ice pack storage and infection control was requested, but not provided.

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

01 1970 Building and 1979 addition

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Perham Memorial Home 01 Main Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 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, Health Care Facilities Code

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/15/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245486	A. BUILDING 01 - 1970 BUILDING B. WING	06/27/2017

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
K 000	Continued From page 1	K 000		

HEALTH CARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION
444 CEDAR STREET, SUITE 145
ST. PAUL, MN 55101-5145, or

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

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

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

2. The actual, or proposed, completion date.

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

This facility was surveyed as 2 separate buildings:

Perham Memorial Home 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 north west of the 1970 building and was determined to be of Type

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

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K 000	Continued From page 2 II(222) construction. The building is divided into 6 smoke compartments by 30- minute, 1- hour and 2- hour fire barriers. 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 facility is completely protected by an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems . The facility has a fire alarm system with smoke detectors in the corridors, spaces open to the corridors and in all resident rooms that is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code". The facility has a capacity of 96 beds and had a census of 88 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is **NOT MET** as evidenced by:	K 000		
K 131 SS=D	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: * They are not intended to serve four or more inpatients. * They are separated from areas of health care occupancies by construction having a minimum 2-hour fire resistance rating in accordance with Chapter 8. * The entire building is protected throughout by an	K 131		9/30/17

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K 131	Continued From page 3 approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This **STANDARD** is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the proper 2 hour fire resistive ratings for occupancies as described in the Life Safety Code (NFPA 101) 2012 edition section 19.1.3.3. This deficient practice could allow for the transfer of smoke or fire from another occupancy and affecting an undetermined amount of staff and visitors. Findings include: At 11:00 am on 06/28/2017 observations revealed the cross corridor doors in the 2 hour fire barrier adjacent to the facility administrators office were only 20 minute doors. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Supervisor.	K 131	New doors ordered for the area of concern to allow for maintenance of 2 hours fire barrier, door company also scheduled to visit for assessment of doors to determine most appropriate action for facility regarding more fiscally viable options. They will be replaced upon receipt; however, manufacturer has indicated that the new doors will arrive after August 8, 2017.	
K 341 SS=E	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control	K 341		8/8/17

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K 341	Continued From page 4 unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (2012) section 19.3.4.1, 9.6.1.3 and NFPA 72 National Fire Alarm Code (2010) section 17.7.4.1. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect 13 of the 88 residents and an undetermined amount of staff and visitors. Findings include: On 06/28/2017 observations revealed smoke detectors within 36 inches of a diffuser in the following locations; 1. At 12:45 pm in the transition wing dining area 2. At 12:47 pm in the laundry room in the transition wing This deficient condition was confirmed by the Facility Administrator and the Environmental Services Supervisor..	K 341	All smoke detectors and/or diffusers in the area of concern will be relocated to accommodate a minimum of 36 inches between the two devices. The project will be completed and substantial compliance achieved by August 8, 2017.	
K 372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier	K 372		8/8/17

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K 372	Continued From page 5 Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain one of four smoke barriers as required by the 2012 Life Safety Code (NFPA 101) section 19.3.7.3, 8.8.7.1 (1). This deficient practice could allow smoke to transfer from one smoke compartment to another affecting the exiting of 13 of the 88 residents and an undetermined amount of staff and visitors. Findings include: At 11:15 am on 06/28/2017 observations revealed the construction of the smoke barrier wall of the transition wing adjacent to the elevator did not extend to the roof deck and has several large penetrations without the proper fire stopping. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Supervisor.	K 372	Smoke barrier construction completed in accordance with Life Safety Code. Project completed by August 8, 2017.	
K 521 SS=B	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall	K 521		8/8/17

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K 521	Continued From page 6 comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain proper exhaust throughout all resident wings as required by the 2012 Life Safety Code (NFPA 101) section 9.2.2 and NFPA 91 Standard for Exhaust Systems for Air Conveying of Vapors, Gases, Mists and Noncombustible Particulate Solids. This deficient practice could negatively affect 13of the 88 residents and an undetermined amount of staff and visitors. Findings include: At 1:00 pm on 06/28/2017 observations revealed the bathroom exhaust was not properly operating in the transition wing. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Supervisor.	K 521	Facility HVAC system measured for appropriate levels of exhaust and adjusted accordingly. Ongoing monitoring will take place to ensure appropriate levels maintained by facility maintenance staff. Corrective action will be completed by August 8, 2017.	
K 712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established	K 712		8/8/17

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K 712	Continued From page 7 routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to provide documentation of fire drills at least quarterly on each shift as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all 88 residents and an undetermined amount of staff and visitors. Findings include: At 9:15 am on 06/28/2017 documentation review revealed there was no record of fire drills being conducted during the 2nd and 3rd shift of the second quarter and on the 3rd shift of the 3rd quarter in 2016. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Supervisor.	K 712	Staff education provided on the fire drill requirements and process adjusted to accommodate facility shifts. Fire drills for missing shifts completed upon survey exit to ensure appropriate staff training in the event of a fire. Corrective action will be completed by August 8, 2017 and monitored on a quarterly basis by facility Safety Director. Results will be reviewed at QAPI.	
K 923 SS=D	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.	K 923		8/8/17

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K 923	Continued From page 8 >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to store oxygen tanks in accordance with NFPA 99 (Health Care Facilities Code) 2012 edition section 11.6.2.3 item 11. This deficient practice could accelerate the spread of fire. This condition could affect an undetermined amount of staff and visitors.	K 923	Combustible materials removed from oxygen storage area. Education provided to staff and oxygen vendors to ensure future compliance. Results will be audited for 12 weeks by Assistant Director of Nursing or designee. Corrective action will be completed by August 8, 2017.	

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K 923	Continued From page 9 Findings include: At 2:40 pm on 06/28/2017 observations revealed combustibles within 5 feet of oxygen bottles in the basement oxygen storage room. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Director.	K 923		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

02 2005 Building

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Perham Memorial Home 01 Main Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 New Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/15/2017

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

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K 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility was surveyed as 2 separate buildings: Perham Memorial Home 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 north west of the 1970 building and was determined to be of Type II(222) construction. The building is divided into 6	K 000		

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K 000	Continued From page 2 smoke compartments by 30- minute, 1- hour and 2- hour fire barriers. The facility is completely protected by an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems . The facility has a fire alarm system with smoke detectors in the corridors, spaces open to the corridors and in all resident rooms that is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code" . The facility has a capacity of 96 beds and had a census of 88 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is **NOT MET** as evidenced by:	K 000		
K 341 SS=E	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8	K 341		8/8/17

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K 341	Continued From page 3 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (2012) section 19.3.4.1, 9.6.1.3 and NFPA 72 National Fire Alarm Code (2010) section 17.7.4.1. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect 9 of the 42 residents and an undetermined amount of staff and visitors. Findings include: At 1:40 pm on 06/28/2017 observations revealed smoke detectors within 36 inches of a diffuser in the soiled utility rooms in the Pine Harbor wing and the Harvest Glen wing. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Supervisor.	K 341	All smoke detectors and/or diffusers in the area of concern will be relocated to accommodate a minimum of 36 inches between the two devices. The project will be completed and substantial compliance achieved by August 8, 2017.	
K 712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and	K 712		8/8/17

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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
K 712	Continued From page 4 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to provide documentation of fire drills at least quarterly on each shift as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all 46 residents and an undetermined amount of staff and visitors. Findings include: At 9:15 am on 06/28/2017 documentation review revealed there was no record of fire drills being conducted during the 2nd and 3rd shift of the second quarter and on the 3rd shift of the 3rd quarter in 2016. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Supervisor.	K 712	Staff education provided on the fire drill requirements and process adjusted to accommodate facility shifts. Fire drills for missing shifts completed upon survey exit to ensure appropriate staff training in the event of a fire. Corrective action will be completed by August 8, 2017 and monitored on a quarterly basis by facility Safety Director. Results will be reviewed at QAPI.	