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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: L6DU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00438

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/06/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	96			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supevisor 09/14/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/14/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/14/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245486

September 14, 2015

Ms. Katie Lundmark, Administrator
Perham Living
735 Third Street Southwest
Perham, Minnesota 56573

Dear Ms. Lundmark:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective July 21, 2015 the above facility is certified for:

96 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

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

Sincerely,

Mark Meath

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

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 11, 2015

Ms. Katie Lundmark, Administrator
Perham Living
735 Third Street Southwest
Perham, Minnesota 56573

RE: Project Number S5486024

Dear Ms. Lundmark:

On June 25, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 12, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On August 6, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 31, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 12, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 21, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 12, 2015, effective July 21, 2015 and therefore remedies outlined in our letter to you dated June 25, 2015, will not be imposed.

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

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

Sincerely,

Mark Meath

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

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245486	A. Building B. Wing	8/6/2015

Name of Facility	Street Address, City, State, Zip Code
PERHAM LIVING	735 THIRD STREET SOUTHWEST PERHAM, MN 56573

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 07/21/2015	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 07/21/2015	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 07/21/2015
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By GA/mm	Date: 08/11/2015	Signature of Surveyor: 28034	Date: 08/06/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 6/12/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245486	A. Building B. Wing **01 - 1970 BUILDING**	7/31/2015

Name of Facility	Street Address, City, State, Zip Code
PERHAM LIVING	735 THIRD STREET SOUTHWEST PERHAM, MN 56573

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **06/12/2015**	ID Prefix	Correction Completed **06/12/2015**	ID Prefix	Correction Completed **07/20/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0011		LSC K0052		LSC K0056	
ID Prefix	Correction Completed **06/12/2015**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0147		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/mm	08/11/2015	27200	07/31/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 6/11/2015

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245486	A. Building B. Wing 02 - 2005 BUILDING	7/31/2015

Name of Facility	Street Address, City, State, Zip Code
PERHAM LIVING	735 THIRD STREET SOUTHWEST PERHAM, MN 56573

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0011	Correction Completed **06/12/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/MM	Date: 08/11/2015	Signature of Surveyor: 27200	Date: 07/31/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 6/11/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: L6DU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00438

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/12/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	96			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Christina Martinson, HFE NEII 07/09/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 07/13/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
June 25, 2015

Ms. Katie Lundmark, Administrator
Perham Living
735 Third Street Southwest
Perham, Minnesota 56573

RE: Project Number S5486024

Dear Ms. Lundmark:

On June 12, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), 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
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 July 21, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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

- 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 11, 2015 (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 11, 2015 (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 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.

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us

Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

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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 _____	06/12/2015

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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		7/21/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/30/2015

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

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F 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a care plan was developed to address bruising for 1 of 3 residents (R124) reviewed for non-pressure related skin conditions Finding include: R124's Order Summary Report dated 6/12/15, revealed R124 had diagnoses which included diabetes mellitus,chronic heart failure and chronic kidney failure. R124's Order Summary Report included various orders which included Prednisone 20 milligrams (mg) daily and clopidogrel bisulfate (Plavix) (platelet inhibitor) 75 mg daily. R124's most recent 14 day Minimum Data Set (MDS) dated 5/27/15, revealed R124 had moderate cognitive impairment and required assistance from staff for all activities of daily living (ADLs). R124's care plan dated 5/13/15, identified R124 was at risk for development of pressure ulcers, and listed various interventions which included pressure relieving device in wheelchair and bed. However, R124's care plan did not identify bruising or potential for further bruising. or skin injuries. R124's care plan lacked any interventions for monitoring current bruising , monitoring for potential bruising and interventions to prevent further potential bruising. R124's Skin Integrity Admission Review dated	F 279	F279 Develop Comprehensive Care Plans The RN Care Coordinator of Transitions completed a skin assessment of R124 on 6/12/15 and again on 6/18/15. Staff education was provided to implement weekly skin assessments for all residents who have an identified skin problem on their care plan in the Transitions household. On a facility wide basis, Nursing Assistants are being educated to enter a new alert, following the eINTERACT STOPandWATCH protocol, for any subtle skin change in condition in documentation software. This will alert RN's for further evaluation. The Skin Care policy will be reviewed and revised as appropriate by the Director of Nursing. The Director of Nursing will complete random audits of the newly implemented STOPandWATCH and change in condition documentation and report findings at the August Quality of Care (Quality Assurance) Committee meeting. Responsible Person: Director of Nursing or designee	

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F 279	Continued From page 2 5/13/15, indicated R124 had extensive bruising on top of left hand and outer left forearm. bruising across entire top right hand, and multiple pea sized reddened area to bilateral arms. R124's RN Assessments dated 5/14/15 indicated R124's "skin was pink, warm, dry and intact. Scattered bruising noted throughout, is on Plavix." The 3 day assessment dated, 5/15/15 revealed no documentation regarding skin condition, assessment dated 5/27/15 revealed "skin warm, pink and normal" and 6/8/15 revealed no documentation regarding skin. Review of R124's nursing progress notes, treatment sheets and medication administration sheets from 5/13/15 to 6/11/15 lacked any other documentation regarding bruising injuries or monitoring of any areas for resolution. During observation on 6/8/15 at 5:01 p.m. R124 was sitting in his wheelchair in his room and was noted to have multiple bruises of different shapes and sizes on his right and left hands and forearms that were dark purple/red in color. During observation on 6/10/15 at 8:17 a.m. R124 is in the dining room and continues to have multiple bruises of different shapes and sizes on his right and left hands and forearms that were dark/light purple/red in color and in different stages of the healing process. During interview on 6/10/15 at 8:41 a.m. R124 confirmed multiple bruises on both hands and arms. R124 stated "I bump my skin, its from the blood thinner and Prednisone." During interview on 6/11/15 at 1:53 p.m.	F 279		

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F 279	Continued From page 3	F 279		

registered nurse (RN)-B confirmed R124 had multiple bruises on his hands/forearms and verified there was no documentation to support that staff was monitoring R124's skin for bruising and there were no interventions in place to prevent further bruising. She indicated she was not aware why monitoring had not been done and indicated this was not the usual facility practice. RN-B stated "I believe we should be monitoring and we normally care plan this type of stuff." RN-B verified staff should be monitoring skin daily and reporting any changes to the nurse.

During interview on 6/11/15 at 2:04 p.m. RN-A confirmed R124 had multiple bruises on his hands/forearms. RN-A verified the lack of documentation to support staff was monitoring R124's skin for bruising and verified no interventions were in place to prevent further bruising. RN-A stated "there should be better documentation on his bruising." Furthermore RN-A stated "they are from hitting himself and bumping his arms on things."

During interview on 6/11/15 at 2:54 p.m. RN-C confirmed R124 had multiple bruises on his hands/forearms. RN-C also verified there was no documentation to support that staff was monitoring R124's skin for bruising, there were no interventions in place to prevent further bruising. She stated the usual facility practice was to monitor resident's skin every day with cares, report anything out of the ordinary, and implement interventions to prevent further injury.

Review of facility policy, titled Skin Care, revised on 12/12, indicated staff to identify and assess resident whose clinical conditions increase the risk for impaired skin integrity, implement

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F 279	Continued From page 4 prevention measures, monitor skin integrity, and provide appropriate modalities for pressure ulcers, wounds and other skin conditions. Under subtitle "Monitoring of Skin Integrity" indicated staff would daily observe skin during care by the nursing assistant and skin concerns are to be reported immediately to the licensed nurse and weekly skin audits on the bath/shower day will be performed for all residents to identify any new alterations in skin integrity and care plan will address skin integrity.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care plan interventions for fall prevention were to minimize the risk of further falls for 1 of 1 resident (R74) reviewed for accidents. Findings include: R74's current care plan dated 4/21/15 indicated R74 was at risk for falls related to de-conditioning and use of antidepressant medication. The care plan instructed staff to use a front wheeled walker and directed staff for extensive assistance of one with transfers and ambulation. R74's walker was to be placed at bed side post fall on 5/10/15 as a fall intervention technique to prevent	F 282	F282 Services by Qualified Person/Per Care Plan The RN Care Coordinator of Transitions Household provided staff education on 6/12/15 regarding the importance of following the care assignment sheet for R74. The RN Care Coordinator of Transitions Household provided staff education on 6/12/15 regarding the importance of following the care assignment sheet for all residents. The Director of Nursing reviewed and revised the facility policy on Care Planning. White boards will be implemented and installed to provide additional documentation of residents special needs as noted on the	7/21/15

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F 282	Continued From page 5 further falls. Review of the current nursing assistant assignment sheet provided by the facility indicated R74 was to have walker placed at bed side within reach, and assist R74 with ambulation to and from bathroom. During observation of morning cares 6/10/15 at 8:09 a.m. R74 was seated on the edge of her bed, wearing her pajamas and oxygen running continuous via nasal cannula. R74's walker was not observed at her bedside and her wheel chair was observed across the room in front to the TV stand. -8:21 a.m. nursing assistant (NA)-B entered R74's room and assisted her to the bathroom. NA-B brought her walker from the far end of the bed, and assisted R74 to ambulate to the bathroom. NA-B proceeded to assist R74 with toileting, and then exited room briefly. -8:31 a.m. NA-B returned to the bathroom to assist R74 with her morning cares, at 8:34 a.m. NA-B came out of the bathroom, then proceeded to move R74's wheel chair from in front of the TV stand into the bathroom, and assisted R74 to stand with her walker and ambulate to sit down in her wheelchair. NA-B continued to assist R74 with her morning cares. At 8:38 a.m. NA-B wheeled R74 down to the dining room to eat breakfast. -9:43 a.m. R74 was observed alone in her room, resting in bed. R74's walker was observed across the room from R74, in front of the TV stand. During interview on 6/10/15 1:47 p.m. NA-B confirmed R74 needed assistance by staff for ambulation and transfers. She verified R74's	F 282	care plan and assignment sheets. Residents and families will be oriented to the purpose of the white boards upon admission. RNCC will complete audits of the assignment sheets being followed and will report to the August Quality of Care (Quality Assurance) Committee meeting. Responsible Person: Director of Nursing of designee	

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F 282	Continued From page 6 current care plan and nursing assistant assignment sheets. NA-B indicated she was not aware R74's walker was to be placed at the bedside. She stated she should of been following R74's care plan and stated "I did not know they put the walker on her care plan, I must have missed it." During interview on 6/11/15 at 3:29 p.m. registered nurse (RN)-A confirmed R74 needed assistance by staff for ambulation and transfers. RN-A also verified R74's current care plan and nursing assistant assignment sheets and verified R74 had a fall when she first came in and the intervention was to place R74's walker at her bedside to prevent further falls. RN-A also confirmed staff should of been following R74's care plan and stated "yes they should be following the care plan and making sure the walker is at bedside." Review of facility policy titled, Care Planning Process, revised on 4/12, indicated every resident shall have an individualized, interdisciplinary plan of care. The interdisciplinary plan of care is based upon the comprehensive assessments completed by the team members within the first 21 days after admission incorporating all information and resident preferences from the team, family and resident. The RN designee coordinates the process for the resident, alerts the multidisciplinary team to major changes in the residents condition which results in the need to reassess the plan of care of the resident.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		7/21/15

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F 323	Continued From page 7 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure consistent fall safety measures were in place to minimize the risk for further falls for 1 of 1 resident (R74) reviewed for accidents. Findings include: R74's admission Minimum Data Set (MDS) dated 4/26/25, indicated R74 was moderately cognitively intact and required extensive assistance of one staff for ambulation and extensive assist of two persons for transfers. The MDS also indicated R74 was not steady and only stabilized with staff assistance for walking and transitioning. Further, the MDS identified R74 required the use of a walker for ambulation. R74's Fall Risk Assessment completed on 4/21/15 , identified R74 was at increased risk for falls and required hands on assistance to move from place to place. Review of R74's Post Fall Safety Report dated 5/10/15, at 7:00 a.m. revealed R74 was found laying on the floor in her room near the bathroom door. R74 stated she was going to the bathroom	F 323	F323 Free of Accident Hazards/Supervision/Devices The RN Care Coordinator of Transitions Household provided staff education on 6/12/15 regarding the importance of following the care assignment sheet for R74. The RN Care Coordinator of Transitions Household provided staff education on 6/12/15 regarding the importance of following the care assignment sheet for all residents. White boards will be implemented and installed to provide additional documentation of residents special needs as noted on the care plan and assignment sheets. Residents and families will be oriented to the purpose of the white boards upon admission. RNCC will complete audits of the assignment sheets being followed and will report to the August Quality of Care (Quality Assurance) Committee meeting. Responsible Person: Director of Nursing of designee	

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F 323	Continued From page 8 and thought she could make it. R74 was not using her walker during the time of the fall, and walker was out of reach. The report identified the immediate intervention was to place walker at bed side and education given about calling for staff to assist. During observation of morning cares 6/10/15 at 8:09 a.m. R74 was seated on the edge of her bed, wearing her pajamas and oxygen running continuous via nasal cannula. R74's walker was not observed at her bedside and her wheel chair was observed across the room in front to the TV stand. -8:21 a.m. nursing assistant (NA)-B entered R74's room and assisted her to the bathroom. NA-B brought her walker from the far end of the bed, and assisted R74 to ambulate to the bathroom. NA-B proceeded to assist R74 with toileting, and then exited room briefly. -8:31 a.m. NA-B returned to the bathroom to assist R74 with her morning cares, at 8:34 a.m. NA-B came out of the bathroom, then proceeded to move R74's wheel chair from in front of the TV stand into the bathroom, and assisted R74 to stand with her walker and ambulate to sit down in her wheelchair. NA-B continued to assist R74 with her morning cares. At 8:38 a.m. NA-B wheeled R74 down to the dining room to eat breakfast. -9:43 a.m. R74 was observed alone in her room, resting in bed. R74's walker was observed across the room from R74, in front of the TV stand. R74's current care plan dated 4/21/15 indicated R74 was at risk for falls related to de-conditioning and use of antidepressant medication. The care plan instructed staff to use a front wheeled	F 323		

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F 323	Continued From page 9	F 323		

walker and directed staff for extensive assistance of one with transfers and ambulation. R74's walker was to be placed at bed side post fall on 5/10/15 as a fall intervention technique to prevent further falls.

Review of the current nursing assistant assignment sheet provided by the facility indicated R74 was to have walker placed at bed side within reach, and assist R74 with ambulation to and from bathroom.

During interview on 6/10/15 1:47 p.m. NA-B confirmed R74 needed assistance by staff for ambulation and transfers. She verified R74's current care plan and nursing assistant assignment sheets. NA-B indicated she was not aware R74's walker was to be placed at the bedside. She stated she should of been following R74's care plan and stated "I did not know they put the walker on her care plan, I must have missed it."

During interview on 6/11/15 at 3:29 p.m. registered nurse (RN)-A confirmed R74 needed assistance by staff for ambulation and transfers. RN-A also verified R74's current care plan and nursing assistant assignment sheets and verified R74 had a fall when she first came in and the intervention was to place R74's walker at her bedside to prevent further falls. RN-A also confirmed staff should of been following R74's care plan and stated "yes they should be following the care plan and making sure the walker is at bedside."

Review of facility policy titled, Care Planning Process, revised on 4/12, indicated every resident

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F 323	Continued From page 10 shall have an individualized, interdisciplinary plan of care. The interdisciplinary plan of care is based upon the comprehensive assessments completed by the team members within the first 21 days after admission incorporating all information and resident preferences from the team, family and resident. The RN designee coordinates the process for the resident, alerts the multidisciplinary team to major changes in the residents condition which results in the need to reassess the plan of care of the resident.	F 323		

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K 000	INITIAL COMMENTS 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 substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS	K 000	EPOC	

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K 000	Continued From page 1 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 Barbara.lundberg@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 8 smoke compartments by 30- minute, 1- hour and	K 000		

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 _____	**06/11/2015**

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

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K 000	Continued From page 2 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 1999 edition. 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" 1999 edition. All areas requiring automatic fire detection in accordance with the Minnesota State Fire Code (MSFC) 2007 edition have been installed. The facility has a capacity of 96 beds and had a census of 93 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was	K 011	K011-Both the penetrations described	6/12/15

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	245486	A. BUILDING **01 - 1970 BUILDING** B. WING _____	**06/11/2015**

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K 011	Continued From page 3 revealed that 1 of multiple fire separations that were found not in compliance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.1.1.4.1 and 19.1.1.4.2,. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect the residents, staff and visitors of the facility. Findings include: On facility tour between 10:00 AM to 2:00 PM on 06/11/2015, observations revealed that there were 2 penetrations located in the 2 hour fire separation between the existing care center and the 2005 addition. 1 of the penetrations were not completely sealed, and the other penetration was located around a wire conduit. This deficient condition was verified by the Maintenance Supervisor (JS).	K 011	were sealed on 6/12/2015 with an approved fire caulk. Environmental Services Staff were educated on importance of sealing penetrations. Fire and smoke separations walls will be inspected and monitored on a regular basis to ensure penetrations do not exist. Responsible Person: Jeff Siebels, Director of Environmental Services or designee.	
K 052 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052		6/12/15

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K 052	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 2-3.4.5.1.2, 2-3.5.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting residents, staff, and visitors of the facility. Findings include: On facility tour between 10:00 AM to 2:00 PM on 06/11/2015, observations revealed that there was a smoke detectors located in the Harvest Glen electrical room that was installed within 36 inches of a HVAC diffuser. This deficient condition was verified by the Maintenance Supervisor (JS).	K 052	K052-The smoke detector described was relocated on 6/12/2015 so ensure it is now more than 36¿ from the HVAC diffuser. Environmental Services Staff were educated on importance of smoke detector placement. The smoke detector placement will be monitored on a casual basis to ensure compliance. Responsible Person: Jeff Siebels, Director of Environmental Services or designee.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water	K 056		7/20/15

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K 056	Continued From page 5 supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect the residents, visitors and staff of the facility. Findings include: On facility tour between 10:00 AM to 2:00 PM on 06/11/2015, observations revealed that there are two different type of sprinkler heads located in the chapel consisting of both standard response and quick response which are combined in one compartment. This deficient condition was verified by the Maintenance Supervisor (JS).	K 056	K056-An appointment has been made with the NOVA Fire Protection to replace sprinkler heads as described as out of compliance located in the material management storage and laundry area. Any new/replacement sprinkler heads will be reviewed to ensure compliance. Responsible Person: Jeff Siebels, Director of Environmental Services or designee. The Federal Report indicates location is in Chapel area, which incorrect. The correct location is noted as above.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		6/12/15

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K 147	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and interview with the staff the facility was not limiting storage near electrical devices in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect the safety of residents, staff and visitors of the facility. Findings include: On facility tour between 10:00 AM to 2:00 PM on 06/11/2015, observations revealed that there was an excessive amount of combustible items being stored around and up against the 480 volt electrical transformer that is located in the lower level mechanical/electrical storage room. This deficient condition was verified by the Maintenance Supervisor (JS).	K 147	K147-Combustiable materials were removed from area noted near the electrical transformer in the lower level mechanical/electrical storage room on 6/12/2015. Appropriate and clear signage was added to ensure visual notices are in place to inform staff of non-placement. The storage in this room will be monitored on a daily basis. Responsible Person: Jeff Siebels, Director of Environmental Services or designee.	

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	245486	A. BUILDING **02 - 2005 BUILDING** B. WING _____	**06/11/2015**

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K 000	INITIAL COMMENTS 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 substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS	K 000	EPOC	

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

Electronically Signed | 06/30/2015

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 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that 1 of multiple fire separations that	K 011	K011-Both the penetrations described were sealed on 6/12/2015 with an	6/12/15

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K 011	Continued From page 3 were found not in compliance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 18.1.1.4.1 and 18.1.1.4.2,. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect the residents, staff and visitors of the facility. Findings include: On facility tour between 10:00 AM to 2:00 PM on 06/11/2015, observations revealed that there were 2 penetrations located in the 2 hour fire separation between the existing care center and the 2005 addition. 1 of the penetrations were not completely sealed, and the other penetration was located around a wire conduit. This deficient condition was verified by the Maintenance Supervisor (JS).	K 011	approved fire caulk. Environmental Services Staff were educated on importance of sealing penetrations. Fire and smoke separations walls will be inspected and monitored on a regular basis to ensure penetrations do not exist. Responsible Person: Jeff Siebels, Director of Environmental Services or designee.	