Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 23, 2020

Administrator
Perham Living
735 Third Street Southwest
Perham, MN 56573

RE: CCN: 245486
Cycle Start Date: April 29, 2020

Dear Administrator:

On June 17, 2020, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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

Electronically delivered
May 12, 2020

Administrator
Perham Living
735 Third Street Southwest
Perham, MN 56573

SUBJECT: SURVEY RESULTS
CCN: 245486
Cycle Start Date: May 12, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES
The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS
On April 29, 2020, the Minnesota Department of Health completed a COVID-19 Focused Survey at Perham Living to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION
You must submit an acceptable electronic plan of correction (ePOC) for the enclosed deficiencies that were cited during the April 29, 2020 survey. Perham Living may choose to delay submission of an ePOC until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit an ePOC. An acceptable ePOC will serve as your

allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation.

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

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

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
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the April 29, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Gail Anderson, Unit Supervisor
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Perham Living may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES
The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

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

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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 ______	04/29/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 focused Infection Control survey was conducted 4/28/20 and 4/29/20 at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations § 483.73(b)(6). The facility was in compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facilty acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 focused Infection Control survey was conducted 4/28/20, to 4/29/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was not in full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable electronic POC, an revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		5/13/20

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

Electronically Signed — 05/13/2020

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 880	Continued From page 1 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		

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F 880	Continued From page 2 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facilty failed to implement a comprehensive infection control program to include recommended COVID-19 staff and visitor health screening procedures. This deficient practice had the potential to affect all 84 residents residing in the facility and all facility staff.	F 880	All staff members have been actively screened and appropriate infection control procedures regarding the screening process are followed to ensure immediate compliance. To ensure ongoing compliance, systems have been adapted to include updating	

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F 880	Continued From page 3	F 880		

F 880 (summary statement):

Findings include:

During observations on 4/28/20, at 11:00 a.m. on the right side of the front entrance was a desk, a plastic container was observed, which held homemade masks, sanitizer, a thermometer, and a binder lying on the desk. The binder had an unlabeled form, dated 4/28/20. The form had spaces for name, fever, symptoms, close contact, worked in another facility, ok to work, excluded from duty and and initials of person completing the screen.
- at 11:01 a.m activity aid (AA)-A entered the front door entrance of the building wearing a mask, stepped up to the desk on the right side of the entrance, took her own temperature, filled out the questions on the form, santitizer her hands and proceeded to enter the facility.
- at 1:10 p.m. registered nurse (RN)-A entered the front entrance of the building using her badge and put a homemade mask on. Two males out in the entry way followed RN-A into the building as she stood in front of the table to the right of the main entrance and waited behind her. RN-A proceeded to take her own temperature, filled out the questions on the form, sanitized her hands and entered the facility. During this time Visitor (V)-A stepped up to the desk on the right side of the entrance, took his own temperature, filled out the questions on the form, sanitized his hands, put on a homemade mask, while V-B stood behind him in line. V-A proceeded to wait off to the left side of the entrance while V-B stepped up to the desk on the right side of the entrance, took his own temperature, filled out the questions on the form, sanitized his hands, put on a homemade mask and proceeded to enter the

F 880 (provider's plan of correction):

the screening form to clarify the need for active screening by or verified by another individual who has an understanding of the symptoms, all staff have been trained on the requirement for active screening, hand hygiene and infection control practices during screening, and to notify the charge nurse to actively screen them prior to entering the building before starting the shift if an active screener is not present at the front door.

Staff educated that all vendors and visitors must be actively screened and may not enter the building without being screened by a trained screener. The screener schedule has been enhanced and is available online to promote a clearer handoff between screeners. The doors are closed to the public and signage has been added to indicate requirement of notifying the charge nurse to conduct screening prior to entering the building, as well as providing a continuous reminder to staff of the need for active screening.

The effectiveness of these changes will be verified after each shift by administration and the system will be audited by Infection Control/Designee 3 times per week for 6 weeks. Results will be monitored by QAPI.

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F 880	Continued From page 4 facility with V-A. - The administrator came around the corner of the hallway, approached V-A and V-B and asked them if they had symptom screening. Both V-A and V-B indicated the screening had been done, indicated they had come to the facility to work on the sprinkler system in the building and proceeded to enter the facility. On 4/28/20 at approximately 1:15 p.m. the administrator confirmed facility staff were not present at the entrance and V-A and V-B had not been screened by facility staff. She indicated this was not normal practice and the facility had trained screeners to screen anyone who entered the building. The administrator indicated she would expect the screeners to screen everybody that came into the building including all employees and all visitors. On 4/28/20 at 1:20 infection control preventionist, (ICP) indicated everyone was to be screened at the front entrance of the building. The ICP indicated the facility has staff assigned as screeners at the front door from 5:00 a.m. to 9 a.m. and 1:30 p.m. to 5:00 p.m. and off hours charge nurses help out or they should call for assistance to be screened. The ICP indicated someone should be at the front entrance to screen people at all times and indicated the screener takes the employees or visitors temperature and asks the screening questions on the sign in sheet. The ICP indicated she would expect the screener to screen the people entering the building or they should be calling someone to complete the screening prior to the visitors entering the facility.	F 880		

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F 880	Continued From page 5	F 880		

On 4/28/20 at 1:43 RN-A confirmed the above findings and indicated she had screened herself when she entered the building to come to work. RN-A indicated she entered the building using her badge, put a mask on, took her own temperature, filled out the form with questions, signed her name, sanitized her hands and proceeded to go to work. RN-A indicated that is her process for symptom screening for COVID-19, if no staff are present at the front desk and indicated she has had to screen herself at times in the past.

On 4/28/20 at 3:28 p.m director of nursing (DON) indicated she would expect staff to be evaluated by the screener or another individual trained when entering the front door. The DON indicated she did not know what happened and indicated she was aware in the past, staff were not at the front desk to screen staff members as they entered the building during these times and they had screened themselves.

In a follow up interview via telephone call on 4/29/20 at 8:21 a.m., the ICP indicated staff and visitors should not be screening themselves and would expect the trained screener to conduct the symptom screening. The ICP indicated the facility expected another person was screening to ensure the integrity of the screening process and to keep the symptoms out of the facility.

Review of facility policy titled, COVID UPDATE undated, indicated under employee screening: all employees should stay home if they are ill, COVID symptoms we screen include fever, cough, shortness of breath and sore throat. If you do not pass the screening log prior to enter to the

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F 880	Continued From page 6 facilty leave work, call the charge RN. Under visitors: only visitors allowed in the facility are family members during end-of-life situations. The policy indicated visitors will be screened at the door and will not be allowed into the facility if they do not pass the screening.	F 880		