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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XWF6

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 **10/17/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 10/22/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/22/2018 (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
10/03/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245486

October 22, 2018

Administrator
Perham Living
735 Third Street Southwest
Perham, MN 56573

Dear Administrator:

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

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

Effective October 2, 2018 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 located in rooms .

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 22, 2018

Administrator
Perham Living
735 Third Street Southwest
Perham, MN 56573

RE: Project Number S5486027

Dear Administrator:

On September 10, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for, a standard survey, completed on August 23, 2018. This survey found the most serious deficiencies 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 October 17, 2018, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 4, 2018 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 extended survey, completed on August 23, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 2, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 23, 2018, effective October 2, 2018 and therefore remedies outlined in our letter to you dated September 10, 2018, 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.

Sincerely,

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XWF6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00438

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(L1) **245486**

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

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(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 **08/23/2018** (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:
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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE - NE II 09/27/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/02/2018 (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 :
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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

September 10, 2018

Administrator
Perham Living
735 Third Street Southwest
Perham, MN 56573

RE: Project Number S5486027

Dear Administrator:

On August 23, 2018, 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 electronically attached CMS-2567 whereby corrections are required.

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 an "F" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

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

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 October 2, 2018, 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 October 2, 2018 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 November 23, 2018 (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 February 23, 2019 (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,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245486	A. BUILDING _____ B. WING _____	08/23/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on August 20,21,22, and 23, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On August 20,21,22, and 23, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident	F 550		10/2/18

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

Electronically Signed | 09/18/2018

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 _____	08/23/2018

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 550	Continued From page 1 with respect and dignity and care for each 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. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a dignified dining experience for 1 of 1 resident (R64) who required assistance with eating in his room. Findings include:	F 550	Staff working with R64 immediately reeducated on providing cares in a dignified manner. All staff educated regarding dignity with dining, positioning, and cares. Policy developed to address resident dignity at Perham Living. Audit	

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 _____	08/23/2018

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 550	Continued From page 2 R64's admission Minimum Data Set (MDS) dated 7/24/18, identified R64 had diagnoses which included heart failure and palliative care with Hospice services. R64's MDS further indicated R64 required extensive to total assistance of one to two staff with all activities of daily living (ADLS) and extensive assistance of one with eating. R64's care plan, revised 7/30/18, instructed staff to provide total assistance of one staff with eating due to an ADL self performance deficit related to recent physical deconditioning, infection and palliative measures. During observation on 8/20/18, at 5:56 p.m. nursing assistant (NA)-D entered R64's room with his food tray. R64 was lying in bed on his left side with bed in the low position. NA-D informed R64's supper was ready and attempted R64 to roll him to his back. R64's torso and head slumped to the left side, with his torso slightly twisted to the left side of the bed. At 6:00 p.m.,with R64 remaining in the slumped position, NA-D proceeded to lean over R64, and attempt to place upper and lower dentures in his mouth. After multiple attempts, NA-D was successful in placing both upper and lower dentures for R64. NA-D attempted to assist R64 to move his upper torso repeatedly without success. R64 remained lying in bed, with his upper torso twisted to the left, head leaning to the left, partially resting on his back. NA-D leaned over R64, raised the head of the bed, R64's body slid down in bed, with his head tilted to the left, not supported by the pillow. R64's knees and hips bent and his feet pressed on the foot board. NA-D leaned over R64 in his low bed and started to assist him to eat his meal. R64 remained in the slumped position in bed,	F 550	will be completed 3 time per week for 12 weeks on Transitions household to ensure staff are caring for residents in a dignified manner by the Transitions RNCC or Designee. Results will be reviewed at QAPI to ensure solutions are sustained.	

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while NA-D continued to lean over R64 while she assisted R64 to eat bites of his meal. At 6:12 p.m., NA-D stopped assisting R64 to eat, carried a chair from across his room and sat down next to R64's bed. NA-D resumed assisting him to eat while he remained in the slouched position in bed. NA-D did not offer or attempt to reposition R64 during the meal. At 6:25 p.m., after R64 had consumed his meal, NA-D removed his meal tray and exited the room. R64 remained in the same slouched position in bed.

On 8/22/18, at 12:04 p.m. NA-C stated R64's health had been declining and was in bed very frequently. NA-C indicated staff would not stand next to R64 while feeding him if he was in the dining room. NA-C indicated it is good to be at eye level with R64 when feeding.

On 8/23/18, at 11:13 a.m. during a telephone interview, NA-C stated R64 required 2 staff members to reposition, and required total assistance with eating. She stated staff were expected to sit down, at eye level, while they assisted residents to eat. NA-C indicated she was unaware if she had stood over R64 while she assisted him to eat in the past.

On 8/22/18, at 12:15 p.m. RN-C stated R64 should not be fed while staff stood over him. RN-C indicated staff should sit next to R64 and attempt to engage R64 in conversation while they assisted him to eat. RN-C indicated she felt it was a dignity concern for staff to stand next to R64 while assisting him to eat.

On 8/23/18, at 10:17 a.m. director of nursing (DON) stated she expected staff to be seated when assisting R64 to eat while in bed.

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F 550	Continued From page 4 A facility policy for dignity was requested, but not provided.	F 550		
F 576 SS=E	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research.	F 576		10/2/18

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F 576	Continued From page 5 (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident mail was delivered on Saturdays for 1 of 1 resident(R24) who voiced concerns with mail delivery. This had the potential to affect all 86 residents residing in the facility. Findings include: On 8/22/18, at 1:00 p.m. a resident council meeting was held with 8 residents from various neighborhoods. During the meeting R24 indicated mail was not delivered on Saturdays. R24 indicated since the new hospital was completed the facility mail went to the hospital, then was brought to the nursing home for delivery. On 8/22/18, at 1:15 p.m. the administrator confirmed mail was not delivered to the facility on Saturdays and stated the mail from the weekend was delivered to residents on Monday. Administrator indicated the usual facility practice was for a courier to bring the resident's mail from the hospital to the facility, then volunteers delivered the mail to the residents. Administrator indicated she had been aware of mail not being delivered on Saturdays for a couple of months. The administrator provided Perham Living QAPI Committee-Minutes dated 5/10/18. The minutes	F 576	Facility staff educated on the need to deliver mail to residents according to regulation. USPS will deliver mail to Perham Health Monday through Friday and directly to Perham Living on Saturday. The mail will be delivered on Saturday by the weekend manager within 24 hours of delivery to the facility. An audit will be completed 1 time per week for 12 weeks by the Administrator or Designee to ensure mail is delivered over the weekend. Results will be reviewed at QAPI to ensure solutions are sustained.	

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F 576	Continued From page 6 identified Saturday mail delivery identified as a concern. Mail was currently not delivered to the hospital on Saturdays. Correction will require post office changing their process of sorting and delivering mail on weekends. The minutes lacked documentation of a plan to have mail delivered on the weekends. Administrator indicated the facility did not have a policy for mail delivery.	F 576		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an environment that was free of accident hazards related to hot water temps on 1 of 6 communities, for 16 of 16 residents (R28, R34, R15, R39, R12, R46, R85, R53, R50, R437, R54, R29, R11, R81, R74, and R56) who resided in the Timber Grove community. Findings include: On 8/20/18, at 12:49 p.m. in room 616, R11's water from the faucet in the shared resident bathroom was hot too the touch.	F 689	Hot water temperature lowered and sensors adjusted to detect temperatures reaching or exceeding 115 degrees and hot water heater temperatures decreased. Alarms on automated system updated to alarm when temperature reaches 115 degrees. Staff educated on safe water temperatures and actions to take if water temperature reaches or exceeds 115 degrees. Maintenance Director or Designee will audit water temperatures 1 time per week for 12 weeks to ensure appropriate and safe temperatures. Results will be reviewed at QAPI to ensure solutions are sustained.	10/2/18

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F 689	Continued From page 7 On 8/20/18, at 1:25 p.m. in room 611, R29's water from the faucet in the shared resident bathroom was hot too the touch. On 8/20/18, at 1:26 p.m. in room 612, R15's water from the faucet in shared resident bathroom was hot too the touch. On 8/20/18, at 1:35 p.m. maintenance personnel was notified of the hot water temperatures and requested they test water temperatures on Timber Grove community. On 8/20/18, at 1:48 p.m. maintenance supervisor (MS)-A arrived on the Timber Grove community with a lap top computer. He reviewed the facility's computerized water temperature monitoring system, which he identified as "Temp Track." MS-A stated the facility had installed a new system two months ago, and would alarm if the water temperatures exceeded the parameters set in the system. MS-A thought the parameters were set at 118 degrees but would verify that with the Lead Engineer (LE). MS-A stated the first resident bathroom on the loop from the recirculating unit was room 616, and requested maintenance staff (M)-A manually test temperatures on the unit. On /20/18, at 2:08 p.m. M-A arrived on the Timber Grove community with a facility thermometer and the following water temperatures were observed for resident bathrooms (RB). -RB 616 temperature reading was 121.2 degrees Fahrenheit (F) -RB 612 temperature reading was 121.4 degrees (F) -RB 611 temperature reading was 121.4 degrees (F)	F 689		

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F 689	Continued From page 8 -RB 601 temperature reading was 121.5 degrees (F) On 8/20/18, at 2:12 p.m. MS-A contacted the LE via telephone, and reported the manual water temperature results. MS-A stated the LE had indicated the high end temperature parameter was currently set at 125 degrees (F). In addition, MS-A stated room 601 was the last room in the system on the Timber Grove community and stated he expected all the temperatures of hot water to be consistent on the same circulating system. MS-A requested the LE to "drop high end alarm to 118." On 8/20/18, at 2:29 p.m., during a follow up interview, MS-A stated the LE was updated with the state water temperature guidelines, and adjusted the facility high end alarm to 115 degrees (F). On 8/20/18, at 5:10 p.m. NA-A stated she was aware of 7 residents who resided on the Timber Grove Community unit and had cognitive impairment with wandering behavior. She identified R39, R50, R11, R437, R15, R74, and R46. On 8/20/18, at 5: 14 p.m. NA-E stated she was aware of several cognitively impaired residents on the unit who wandered in and out of rooms and identified R11 and R74. On 8/20/18, at 6:45 p.m. NA-B identified R85 with cognitive impairment who wandered in and out of rooms daily, but stated there were other residents on the unit who wandered. Policy was requested on water temperature	F 689		

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F 689	Continued From page 9 testing/environmental safety for the facility, none was provided.	F 689		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based upon observation, interview, and	F 726	All applicable staff retrained on	10/2/18

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F 726	Continued From page 10 document review the facility failed to ensure staff competency for disinfection of the common use blood glucometer machines according to current manufacturer's guidelines in three of six neighborhoods (Prairie Knoll, Burlington, and Timber Grove), for 13 of 26 residents (R16, R20, R1, R75, R42, R36, R82, R30, R437, R46, R29, R76, R53) who resided in those neighborhoods and received routine blood glucose testing in the facility. Findings include: On 8/21/18, at 2:59 p.m. registered nurse (RN)-B stated her usual practice for cleaning the glucometer machine included to use alcohol wipes to clean off the surface of the glucometer machine between residents. She stated she cleaned the glucometer machine with wipes in medication storage room when she had completed glucometer checks for all residents on the unit. On 8/22/18, at 7:18 a.m. R29 was seated in recliner in her room. Trained medication aide (TMA)-A entered the room with a small white wheeled cart, with a clear plastic case on the top of the cart. A glucometer machine(Express Stat Strip) was observed in the plastic case, with various blood glucose testing supplies. TMA-A stated the glucometer on the cart was a common use glucometer for the facility. TMA-A donned gloves and cleaned R29's finger with an alcohol wipe and used a new single use disposable lancet to perform R29's finger stick. The lancet was disposed of in sharps container, and TMA-A applied a gauze the R29's finger. TMA-A wiped the glucometer with a wipe from individual packet labeled "PDI Sani-Cloth Bleach" and wiped all	F 726	glucometer cleaning and policy in place to address immediate concerns until individual-use glucometers implemented. Facility will implement procedure for individual-use glucometers for all residents requiring blood glucose testing. DON or Designee will audit nurses on various shifts throughout the facility to ensure appropriate glucometer cleaning 3 times per week for 12 weeks. Results will be reviewed at QAPI to ensure solutions are sustained.	

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surfaces of the glucometer machine for five to six seconds, and immediately placed the wet glucometer back into the storage case. TMA-A stated the PDI Sani-cloth Bleach wipes were used to clean the glucometer between residents. TMA-A stated she had received training on the use of the glucometer about one time per year, most recently was last spring.

On 8/22/18, at 7:31 a.m. licensed practical nurse (LPN)-A entered R29's room and administered insulin to R29. LPN-A stated the usual facility practice was to wipe down the surfaces of the glucometer with PDI sani cloth wipes after use and between residents. She stated she would allow the glucometer to dry before the next use and stated she was unsure how much time was needed for the glucometer to dry.

On 8/22/18, at 7:35 a.m. during a follow up interview TMA-A stated she should have allowed the glucometer to dry for three to five minutes before putting it back in the case.

On 8/22/18, at 8:53 a.m. registered nurse clinical manager (RNCM)-A stated the PDI Sani-Cloth Bleach wipes located in the glucometer storage box, were used to disinfect the common use glucometers. Further, RNCM-A stated the process to disinfect the common use glucometer between residents was to use the PDI Sani-Cloth Bleach wipes to wipe the glucometer down after use, and let it air dry for four minutes. RNCM-A stated if the glucometer was visibly soiled with blood, one wipe would be used to clean off the blood, then a second wipe would be used to wipe down the glucometer a second time and allowed to air dry as usual for four minutes. RNCM-A stated she understood the product required one

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minute of contact time to kill pathogens. RNCM-A reviewed the PDI Sani-Cloth Bleach germicidal disposable wipes package instructions, and confirmed the PDI Sani-Cloth Bleach germicidal disposable wipes product guidelines required the surface to be continuously wet for four minutes wet contact time, then allowed to air dry.

On 8/23/18, at 9:31 a.m. RN-A stated the process to disinfect the glucometer was to wipe down the glucometer after use, and indicated the machine needed to stay wet for one to four minutes depending on what the residents concern is. RN-A stated she was not aware of any residents with known blood borne pathogens currently in the facility.

On 8/23/18, at 9:40 a.m. the facility staff development coordinator (SDC) stated that glucometer training, cleaning education, and competency for all employees was to be completed upon hire, at orientation by the RNCM or Charge Nurse on unit where they were assigned. The SDC stated the process expected for disinfecting the glucometer between residents was to use the PDI Sani-Cloth bleach wipes. Further, she stated the PDI Sani-Bleach wipes were to remain in contact with glucometer surface, and needed to remain wet for four minutes to properly disinfect the glucometer between residents. The SDC was not able to identify any residents with a known blood borne pathogen in the facility, but stated that staff were routinely trained on universal precautions. In addition, she stated she expected staff to keep the glucometers wet with the PDI Sani-Bleach wipes after use and between residents for four minutes per product guidelines, and was not

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aware of staff not adhering to infection prevention practices in regards to glucometer disinfection between residents.

Review of educational materials provided to RN's, LPN's, and TMA's for staff training for the proper use of the glucose testing equipment, on 7/11/18, included:

-Nova Biomedical Customer Information Bulletin, dated 12/4/12, titled Cleaning and diisnfection Procedure, StatStrip and StatSensor included instructions to "ensure the meter surface stays wet for 1 minute and then is allowed to air dry for an additional 1 minute.

-Nova Biomedical, information sheet, titled StatStrip, Xpress Meter, Glucose Monitoring Instructions for Use of Controls, undated, included to clean with a bleach wipe with 4 minute contact time.

-Nova Biomedical StatStrip, Xpress Meter, Glucose Monitoring Quick Operating Guide, undated, included to clean meter with bleach with with 4 minute contact time.

Review of the facility form titled Competency Testing, StatStrip Xpress Meter Use, dated 2/26/18, included various steps for testing of controls and various steps for proper procedure to obtain and test a blood sample. The form included a step which indicated "cleans and disinfects the meter." However, the form did not include the manufacturer's guidelines for proper disinfection of the common use glucometer.

On 8/23/2018, at 10:08 a.m. the Director of Nursing (DON) confirmed the educational

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F 726	Continued From page 14	F 726		

material provided to staff, and stated she would expect staff to use the PDI Sani-Cloth bleach wipes to disinfect the common use glucometers between each resident per manufactures guidelines. She stated staff education, training, and competency on glucometer use and disinfection was completed upon new hire orientation, and at annual competency skills fair. DON was unaware if glucometer training and disinfecting was included in the last training, but stated the information was reviewed also at the RN/LPN/TMA monthly staff meetings.

On 8/23/18, at 10:38 a.m. assistant director of nursing (ADON)-Infection Control Nurse(ICN) stated last year staff was provided glucometer training, and training was provided upon hire. In addition, RNCM-B stated on April of 2017 training for glucometer use and disinfection was reviewed with staff, and in July of 2018 use of the PDI Sani-Cloth bleach wipes to disinfect the common use glucometers between each residents. RNCM-B stated all staff received information for when and how to use the PDI Sani-Cloth bleach wipes, spot audits of glucometer use were done and education provided as needed. RNCM-B stated new staff education was provided in the individual communities with the RNCM or the RN/LPN charge nurse on duty for that unit. She indicated the staff who provided the training verified competency with a skills checklist during orientation.

Facility policy titled Diabetic Bld Gluc (blood glucose) Testing revised 8/3/18, identified the facility utilized the Precision Xceed Pro Blood Glucose Testing System for all glucose testing in the facilty. The policy directed the monitor to be wiped after use with a sani-cloth germicidal

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	245486	A. BUILDING _____ B. WING _____	08/23/2018

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 726	Continued From page 15 disposable wipe, and to remain wet for the recommended times stated on the sanicloth germicidal and air dry per germicidal instructions. Review of the PDI-SaniCloth Bleach Germicidal Disposable Wipe packing information from the PDI container listed to disinfect use wipe to remove heavy soil with a wipe, use a clean wipe to thoroughly wet surface, and treated surface must remain visibly wet for a full four minutes. Use additional wipes if needed to assure continuous 4 minute wet contact time. Then let air dry.	F 726		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758		10/2/18

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F 758	Continued From page 16 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident was reassessed for continued use of an as needed (PRN) psychotropic medication, Haloperidol (anti-psychotic), beyond the 14 days for 1 of 1 residents (R64) who received an as needed anti-psychotic medication. Findings include: R64's admission Minimum Data Set (MDS) dated 7/24/18, identified R64 was severely cognitively impaired and had diagnoses which included	F 758	Facility staff has provided education to Hospice of the Red River Valley to ensure residents receiving psychotropic medications on a PRN basis will be seen by a hospice provider no more than every 14 days or will have the psychotropic medication discontinued. Facility staff also educated on the need for continuous monitoring of psychotropic medication prescribed on a PRN basis. Policy regarding PRN psychotropic medications updated. All current residents prescribed PRN psychotropic medication reviewed to	

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F 758	Continued From page 17 adjustment disorder with depression, anxiety and palliative care. The MDS indicated R64 was receiving hospice services, required extensive assistance from 2 staff with activities of daily living and required total assistance of one staff with eating. The MDS further identified R64 had no behaviors, received an anti-psychotic medication three times during the seven day look-back period. R64's corresponding Care Area Assessment (CAA) dated 7/27/2018, indicated R64 was severely cognitively impaired, had end-stage heart failure and was under Hospice care due to terminal prognosis. The CAA had further indicated R64 had pain, sleep disturbances, hypoactivity, psychosocial, change in mood, symptom relief or palliative measure and restricted mobility. The CAA identified R64 received Haloperidol for agitation, restlessness and further evaluation of continued use would be completed within the next week. Review of R64's care plan dated 8/23/18, indicated R64 used an anti-psychotic medication. The care plan listed various interventions which included to consult with pharmacy and MD to consider dosage reduction when clinically appropriate. Further, the care plan indicated staff should discuss with MD and family regarding continued use of medication. Review of R64's physician progress notes and orders revealed: R64's Admission Orders dated 7/18/18, included Haloperidol 0.5 mg by mouth every 4 hours as needed for agitation and nervousness. The order further indicated the nurse was to assess	F 758	ensure compliance. DON or Designee will audit psychotropic PRN use for all current residents and medical provider visits 1 time per week for 12 weeks. Results will be reviewed at QAPI to ensure solutions are sustained.	

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F 758	Continued From page 18 use after 14 days (8/1/18). On 8/3/18, a fax was sent to the physician to address Haloperidol orders per pharmacy recommendation. Order was received from the physician via fax to continue Haloperidol 0.5 mg. by mouth every four hours as needed for agitation/ nervousness. No further documentation was noted regarding continued use of Haloperidol. Review of R64's medication administration record from 7/18/18, to 8/23/18, revealed R64 received prn Haloperidol 8 times with the most recent date of 8/22/18. Review of Pharmacist's Monthly Drug Regimen Review Form dated 8/10/18, indicated to continue to reassess Haloperidol prn use every 14 days. Review of the pharmacy consult recommendation dated 8/10/18, indicated R64 should be reassessed for continued use of prn Haloperidol every 14 days. During observation on 8/22/18, at 07:21 a.m. R64 complained of pain to his right side of his abdomen. Registered nurse (RN)-C adminsitered Haloperidol 0.5 mg. by mouth to R64 for agitation. On 8/22/18, at 12:15 p.m. registered nurse RN-C stated an order had been received on 8/3/18 to continue the prn Haloperidol due to agitation and restlessness. RN-C verified the physician should have seen R64 within 14 days to review the continued use of the prn Haloperidol and verified the MD had not seen R64 since admission. RN-C stated the plan was for the physician to	F 758		

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F 758	Continued From page 19 address the continued use of the prn Haloperidol on rounds that same week. On 8/23/18, at 09:07 a.m. pharmacy consultant (PC)-A confirmed prn antipsychotic medications required a rationale for use and an evaluation by a physician within 14 days for continued use. PC-A indicated pharmacy conducts monthly visits and recommendations were written in a notebook stored at the nurses station. PC-A stated pharmacy staff advised facilities on medication dose changes and they relied on facilities to contact the physician to obtain new orders within the required 14 day timeline. On 8/23/18, at 10:17 a.m. director of nursing (DON) verified prn antipsychotic use should be evaluated by a physician within 14 days for continued use of the prn antipsychotic medication. DON stated a physician is required to see the resident in person in order to continue the medication. A facility policy titled Psychotropic Medications, revised on 7/24/18, indicated efforts to reduce dosage or discontinue of psychotropic medications will be ongoing, as appropriate, for the clinical situation. Further, the policy indicated orders for prn psychotropic medications will be time limited (times 2 weeks) and only for specific clearly documented circumstances.	F 758		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		10/2/18

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F 880	Continued From page 20 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; (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	F 880		

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F 880	Continued From page 21 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 facility failed to ensure clean facility linens were handled in a manner that prevented contamination during sorting and folding of the clean linens. This practice had the potential to affect all 86 residents served by the facility laundry. In addition, the facility failed to ensure the common use blood glucometer machines were disinfected according to current manufacturer's guidelines between resident use in three of six neighborhoods (Prairie Knoll, Burlington, and Timber Grove) for 13 of 26 residents (R16, R20, R1, R75, R42, R36, R82, R30, R437, R46, R29, R76, R53) who resided in those neighborhoods and received blood glucose testing in the facility.	F 880	Fan in laundry cleaned and procedure updated to include fan cleaning on a weekly basis by laundry staff. Vents added to monthly maintenance of exhaust ducts. All staff trained on the cleaning routine and cleaning of the fan as it pertains to infection control. Housekeeping Supervisor/Designee will audit fan cleanliness in laundry 1 time per week for 12 weeks. Results will be reviewed at QAPI to ensure solutions are sustained. All applicable staff retrained on glucometer cleaning and policy in place to address immediate concerns until	

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F 880	Continued From page 22 Findings include: On 8/23/18, at 10:10 a.m. during a facility laundry tour with housekeeper (HK)-A, the facility's commercial washing machines were observed. Across from the first machine, was a white Air King fan, which was mounted to the wall a few feet away. The fan's blades were encased with white fins, which were covered in a gray/white substance and had numerous fibers, up to one inch, attached to the fins and blowing in the direction of the first washer, as the fan oscillated. Above the first and second washing machines was a white, forced air vent, blowing cool air into the room. The white vent had 12 half inch fins which were covered in a black/gray film. In a separate clean room, for drying and sorting/folding, the area above the commercial dryers was observed. In the top left corner of the wall were two side by side holes through the walls that went into the next room, which housed mechanical equipment. Surrounding the entire two 6-8 inch holes, were white/gray colored fibers attached around the hole openings. Along the wall was a long sorting and folding counter, where staff were folding and sorting clean linens. Across from the counter was a white vent with seven fins blowing forced cool air directly at the counter. The white fins were covered in a black and gray film. At 10:15 a.m. HK-A indicated the facility laundry cleaned linen for the facility including bedding and towels. She stated she had cleaned the Air King fan in the past, but could not recall when it was last cleaned. HK-A indicated she was unsure who was in charge of cleaning the forced cool air vents, or when they were last done.	F 880	individual-use glucometers implemented. Facility will implement procedure for individual-use glucometers for all residents requiring blood glucose testing. DON or Designee will audit nurses on various shifts throughout the facility to ensure appropriate glucometer cleaning 3 times per week for 12 weeks. Results will be reviewed at QAPI to ensure solutions are sustained.	

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F 880	Continued From page 23 At 10:38 a.m. assistant director of nursing (ADON) indicated she was in charge of infection control for the facility. ADON indicated the facility's residents, due to their age and comorbidities, were at a higher risk for infections. She stated her expectations for fans and vents blowing air onto clean linens was that they would be clean and not blow directly onto clean linen. ADON indicated if the vents and fan were not clean, there would be a potential for an infection control concern. At 11:42 a.m. facility management (FM)-A indicated he was the supervisor for the laundry department. He indicated laundry staff would daily clean the floors and wipe things down and on Saturdays do a deep clean. FM-A indicated there was not a written list of items to be cleaned, and the cleaning was assigned to whomever was working each day. FM-A stated the Air King fan and forced air vents were not on a regular cleaning schedule. He indicated after he observed the fan today, that he would start to have staff clean the fan weekly on Mondays. FM-A indicated the laundry staff were to make an electronic maintenance ticket if the vents were in need of cleaning. After review of the electronic maintenance ticket system, FM-A indicated no open tickets had been made to clean the vents and could not locate when the last time the vents were cleaned. COMMON USE GLUCOMETERS On 8/21/18, at 2:59 p.m. registered nurse (RN)-B stated her usual practice for cleaning the glucometer machine included to use alcohol wipes to clean off the surface of the glucometer	F 880		

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F 880	Continued From page 24	F 880		

machine between residents. She stated she cleaned the glucometer machine with wipes in medication storage room when she had completed glucometer checks for all residents on the unit.

On 8/22/18, at 7:18 a.m. R29 was seated in recliner in her room. Trained medication aide (TMA)-A entered the room with a small white wheeled cart, with a clear plastic case on the top of the cart. A glucometer machine(Express Stat Strip) was observed in the plastic case, with various blood glucose testing supplies. TMA-A stated the glucometer on the cart was a common use glucometer for the facility. TMA-A donned gloves and cleaned R29's finger with an alcohol wipe and used a new single use disposable lancet to perform R29's finger stick. The lancet was disposed of in sharps container, and TMA-A applied a gauze the R29's finger. TMA-A wiped the glucometer with a wipe from individual packet labeled "PDI Sani-Cloth Bleach" and wiped all surfaces of the glucometer machine for five to six seconds, and immediately placed the wet glucometer back into the storage case. TMA-A stated the PDI Sani-cloth Bleach wipes were used to clean the glucometer between residents. TMA-A stated she had received training on the use of the glucometer about one time per year, most recently was last spring.

On 8/22/18, at 7:31 a.m. licensed practical nurse (LPN)-A entered R29's room and administered insulin to R29. LPN-A stated the usual facility practice was to wipe down the surfaces of the glucometer with PDI sani cloth wipes after use and between residents. She stated she would allow the glucometer to dry before the next use and stated she was unsure how much time was

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F 880	Continued From page 25 needed for the glucometer to dry. On 8/22/18, at 7:35 a.m. during a follow up interview TMA-A stated she should have allowed the glucometer to dry for three to five minutes before putting it back in the case. On 8/22/18, at 8:53 a.m. registered nurse clinical manager (RNCM)-A stated the PDI Sani-Cloth Bleach wipes located in the glucometer storage box, were used to disinfect the common use glucometers. Further, RNCM-A stated the process to disinfect the common use glucometer between residents was to use the PDI Sani-Cloth Bleach wipes to wipe the glucometer down after use, and let it air dry for four minutes. RNCM-A stated if the glucometer was visibly soiled with blood, one wipe would be used to clean off the blood, then a second wipe would be used to wipe down the glucometer a second time and allowed to air dry as usual for four minutes. RNCM-A stated she understood the product required one minute of contact time to kill pathogens. RNCM-A reviewed the PDI Sani-Cloth Bleach germicidal disposable wipes package instructions, and confirmed the PDI Sani-Cloth Bleach germicidal disposable wipes product guidelines required the surface to be continuously wet for four minutes wet contact time, then allowed to air dry. On 8/23/18, at 9:31 a.m. RN-A stated the process to disinfect the glucometer was to wipe down the glucometer after use, and indicated the machine needed to stay wet for one to four minutes depending on what the residents concern is. RN-A stated she was not aware of any residents with known blood borne pathogens currently in the facility.	F 880		

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F 880	Continued From page 26 On 8/23/18, at 9:40 a.m. the facility staff development coordinator (SDC) stated the process expected for disinfecting the glucometer between residents was to use the PDI Sani-Cloth bleach wipes. Further, she stated the PDI Sani-Bleach wipes were to remain in contact with glucometer surface, and needed to remain wet for four minutes to properly disinfect the glucometer between residents. The SDC was not able to identify any residents with a known blood borne pathogen in the facility, but stated that staff were routinely trained on universal precautions. In addition, she stated she expected staff to keep the glucometers wet with the PDI Sani-Bleach wipes after use and between residents for four minutes per product guidelines, and was not aware of staff not adhering to infection prevention practices in regards to glucometer disinfection between residents. On 8/23/2018, at 10:08 a.m. the director of nursing (DON) stated she would expect staff to use the PDI Sani-Cloth bleach wipes to disinfect the common use glucometers between each resident per manufactures guidelines. She stated staff education, training, and competency on glucometer use and disinfection was completed upon new hire orientation, and at annual competency skills fair. DON was unaware if glucometer training and disinfecting was included in the last training, but stated the information was reviewed also at the RN/LPN/TMA monthly staff meetings. A policy for cleaning in the laundry room was requested, and none were provided. The facility policy titled Diabetic Bld Gluc (blood	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 27 glucose) Testing revised 8/3/18, identified the facility utilized the Precision Xceed Pro Blood Glucose Testing System for all glucose testing in the facilty. The policy directed the monitor to be wiped after use with a sani-cloth germicidal disposable wipe, and to remain wet for the recommended times stated on the sanicloth germicidal and air dry per germicidal instructions. Review of the PDI-SaniCloth Bleach Germicidal Disposable Wipe packing information from the PDI container listed to disinfect use wipe to remove heavy soil with a wipe, use a clean wipe to thoroughly wet surface, and treated surface must remain visibly wet for a full four minutes. Use additional wipes if needed to assure continuous 4 minute wet contact time. Then let air dry.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245486	A. BUILDING **01 - 1970 BUILDING** B. WING _____	**08/21/2018**

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

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

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:

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

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/18/2018

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	K 000		

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 smoke compartments by 30- minute, 1- hour and 2- hour fire barriers.
In 2016 the east end of the building was

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K 000	Continued From page 2 remodeled and included a new north entrance. This section is separated by a 2 hour fire barrier. The facility was surveyed as one building. 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 85 at the time of the survey.	K 000		
K 211 SS=E	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to be in accordance with NFPA 101 (12) Life Safety Code section 7.1.10.1, which states,	K 211	Chairs and table removed from vestibule and chairs removed from exit corridor. Facility staff educated on appropriate	10/2/18

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K 211	Continued From page 3 all means of egress is to be continuously maintained free of all obstructions to full use in case of emergency. This deficient practice could affect 28 of the 96 residents. FINDINGS INCLUDE: On the facility tour between 9:30 am to 2:30 pm on 08/21/2018 observations revealed 4 chairs constricting the exit in the corridor of Pine Harbor and 2 chairs and a table in the vestibule of Pine Harbor. This deficient condition was confirmed by the Facility Administrator and the Director of Maintenance.	K 211	furniture placement and regulation pertaining to clear exit corridors. Exit corridors and vestibule on Pine Harbor will be audited for constriction 1 time per week for 12 weeks by Administrator or designee.	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A	K 321		10/2/18

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K 321	Continued From page 4 a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility to maintain a hazardous storage room in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect the quick and efficient exiting for 48 of the 96 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:30 am to 2:30 pm on 08/21/2018 Observations revealed the doors of the soiled utility rooms (8) in the 2004 addition were only 20 minute. This deficient condition was confirmed by the Facility Administrator and the Director of Maintenance.	K 321	New doors ordered for Soiled Utility Rooms. Applicable facility staff educated on maintaining appropriate fire ratings on doors. All doors of soiled utility rooms will be replaced with doors rated at 45 minutes for fire. Compliance will be verified by Director of Maintenance or designee.	
K 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101 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,	K 341		10/2/18

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K 341	Continued From page 5 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 This REQUIREMENT 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 an undetermined amount of residents staff and visitors. Findings include: On the facility tour between 9:30 am to 2:30 pm on 08/21/2018 observations revealed 2 smoke detectors within 36 inches of a HVAC diffuser, one in soiled utility room 2642 and one in the lower level oxygen storage room. This deficient condition was confirmed by the Facility Administrator and the Director of Maintenance.	K 341	Facility staff educated on appropriate placement of smoke detectors in reference to HVAC diffusors. Smoke Detectors moved out of range of the diffusers leaving a minimum 36-inch separation. Compliance will be verified by Director of Maintenance or designee.	

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K 754	Continued From page 6	K 754		
K 754 SS=D	Soiled Linen and Trash Containers CFR(s): NFPA 101 Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to properly store soiled linen and trash containers in a protected hazardous room as stated in the Life Safety Code NFPA 101 2012 edition section 19.7.5.7. This deficient practice could affect the safety of an undetermined amount of staff and visitors if smoke or fire from one of these containers made the corridors non-useable. Findings include: On the facility tour between 9:30 am to 2:30 pm on 08/21/2018 observations revealed a trash container over 32 gallons in the lower level corridor next to the kitchen.	K 754	Trash collection receptacle replaced with a smaller sized container. Facility staff educated on the regulation to ensure future compliance. Compliance verified by Administrator or designee.	10/2/18

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K 754	Continued From page 7 This deficient condition was confirmed by the Facility Administrator and the Director of Maintenance.	K 754		

Electronically delivered
September 10, 2018

Administrator
Perham Living
735 Third Street Southwest
Perham, MN 56573

Re: State Nursing Home Licensing Orders - Project Number S5486027

Dear Administrator:

The above facility was surveyed on August 20, 2018 through August 23, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson, Unit Supervisor at (218) 332-5140 or gail.anderson@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00438	A. BUILDING: _____ B. WING _____	08/23/2018

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On August 20,21,22,and 23, 2018, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by:	2 302		10/2/18

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2 302	Continued From page 3 Based on interview, and document review, the facility failed to ensure consumers were provided information regarding Alzheimer's disease and dementia training, including a description of the training program, the categories of employees trained, the frequency of training and the basic topics covered in the training in a written or electronic form. This deficient practice had the potential to affect all 86 residents and their families. Findings include: During a review of the facility's Alzheimer's training program, there was no information or documentation that indicated that the consumers (resident and families) were provided a description of Alzheimer's training program, categories of employees trained, frequency of training and the basic topics covered. On 8/23/18, at 10:35 a.m. Administrator indicated consumer information for the facility Alzheimer's training program was available in the facility knowledge nook. Administrator indicated there was a sign posted which informed consumers where to find the Alzheimer's training program information. Administrator and surveyor went to the area of the Knowledge nook, and no sign was observed in the area. The administrator confirmed no sign was posted in the area. The Knowledge nook was a three shelf bookcase above a built in cupboard which was located in the hallway between the front entrance and the facility. A white 1 and 1/2 inch binder was located on the top shelf, with other books and binders. The binder was labeled Notice Of Employee Training For Alzheimer's And Related Disorders, Combined Federal and State Bill of Rights. Inside the binder contained a one page document titled	2 302	Corrected.	

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2 302	Continued From page 4 Notice of Employee Alzheimer's and Related Disorders Training. The document identified direct care staff and their supervisors received training on dementia upon hire and on an annual basis at a minimum. Administrator indicated she was not sure if the facility's admission packet for residents and families included information for their Alzheimer's training program. On 8/23/18, at 10:48 a.m. Licensed social worker (LSW)-A indicated the facility provided verbal information at time of admission. LSW-A confirmed the facility did not provide written or electronic form to consumers for the facility Alzheimer's training program. A facility policy was requested for Alzheimer's training, one was not provided. SUGGESTED METHOD: The administrator or designee could develop/revise and implement policies and procedures related to the required Alzheimer's training program requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and	21390		10/2/18

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21390	Continued From page 5 control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the common use blood glucometer machines were disinfected according to current manufacturer's guidelines between resident use to prevent cross contamination in three of six neighborhoods (Prairie Knoll, Burlington, and Timber Grove) for 13 of 26 residents (R16, R20, R1, R75, R42, R36, R82, R30, R437, R46, R29, R76, R53) who resided in those neighborhoods and received blood glucose testing in the facility. Findings include: On 8/21/18, at 2:59 p.m. registered nurse (RN)-B	21390	Corrected.	

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stated her usual practice for cleaning the glucometer machine included to use alcohol wipes to clean off the surface of the glucometer machine between residents. She stated she cleaned the glucometer machine with wipes in medication storage room when she had completed glucometer checks for all residents on the unit.

On 8/22/18, at 7:18 a.m. R29 was seated in recliner in her room. Trained medication aide (TMA)-A entered the room with a small white wheeled cart, with a clear plastic case on the top of the cart. A glucometer machine(Express Stat Strip) was observed in the plastic case, with various blood glucose testing supplies. TMA-A stated the glucometer on the cart was a common use glucometer for the facility. TMA-A donned gloves and cleaned R29's finger with an alcohol wipe and used a new single use disposable lancet to perform R29's finger stick. The lancet was disposed of in sharps container, and TMA-A applied a gauze the R29's finger. TMA-A wiped the glucometer with a wipe from individual packet labeled "PDI Sani-Cloth Bleach" and wiped all surfaces of the glucometer machine for five to six seconds, and immediately placed the wet glucometer back into the storage case. TMA-A stated the PDI Sani-cloth Bleach wipes were used to clean the glucometer between residents. TMA-A stated she had received training on the use of the glucometer about one time per year, most recently was last spring.

On 8/22/18, at 7:31 a.m. licensed practical nurse (LPN)-A entered R29's room and administered insulin to R29. LPN-A stated the usual facility practice was to wipe down the surfaces of the glucometer with PDI sani cloth wipes after use and between residents. She stated she would

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allow the glucometer to dry before the next use and stated she was unsure how much time was needed for the glucometer to dry.

On 8/22/18, at 7:35 a.m. during a follow up interview TMA-A stated she should have allowed the glucometer to dry for three to five minutes before putting it back in the case.

On 8/22/18, at 8:53 a.m. registered nurse clinical manager (RNCM)-A stated the PDI Sani-Cloth Bleach wipes located in the glucometer storage box, were used to disinfect the common use glucometers. Further, RNCM-A stated the process to disinfect the common use glucometer between residents was to use the PDI Sani-Cloth Bleach wipes to wipe the glucometer down after use, and let it air dry for four minutes. RNCM-A stated if the glucometer was visibly soiled with blood, one wipe would be used to clean off the blood, then a second wipe would be used to wipe down the glucometer a second time and allowed to air dry as usual for four minutes. RNCM-A stated she understood the product required one minute of contact time to kill pathogens. RNCM-A reviewed the PDI Sani-Cloth Bleach germicidal disposable wipes package instructions, and confirmed the PDI Sani-Cloth Bleach germicidal disposable wipes product guidelines required the surface to be continuously wet for four minutes wet contact time, then allowed to air dry.

On 8/23/18, at 9:31 a.m. RN-A stated the process to disinfect the glucometer was to wipe down the glucometer after use, and indicated the machine needed to stay wet for one to four minutes depending on what the residents concern is. RN-A stated she was not aware of any residents with known blood borne pathogens currently in

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21390	Continued From page 8 the facility. On 8/23/18, at 9:40 a.m. the facility staff development coordinator (SDC) stated the process expected for disinfecting the glucometer between residents was to use the PDI Sani-Cloth bleach wipes. Further, she stated the PDI Sani-Bleach wipes were to remain in contact with glucometer surface, and needed to remain wet for four minutes to properly disinfect the glucometer between residents. The SDC was not able to identify any residents with a known blood borne pathogen in the facility, but stated that staff were routinely trained on universal precautions. In addition, she stated she expected staff to keep the glucometers wet with the PDI Sani-Bleach wipes after use and between residents for four minutes per product guidelines, and was not aware of staff not adhering to infection prevention practices in regards to glucometer disinfection between residents. On 8/23/2018, at 10:08 a.m. the director of nursing (DON) stated she would expect staff to use the PDI Sani-Cloth bleach wipes to disinfect the common use glucometers between each resident per manufactures guidelines. She stated staff education, training, and competency on glucometer use and disinfection was completed upon new hire orientation, and at annual competency skills fair. DON was unaware if glucometer training and disinfecting was included in the last training, but stated the information was reviewed also at the RN/LPN/TMA monthly staff meetings. The facility policy titled Diabetic Bld Gluc (blood glucose) Testing revised 8/3/18, identified the facility utilized the Precision Xceed Pro Blood Glucose Testing System for all glucose testing in	21390		

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21390	Continued From page 9 the facilty. The policy directed the monitor to be wiped after use with a sani-cloth germicidal disposable wipe, and to remain wet for the recommended times stated on the sanicloth germicidal and air dry per germicidal instructions. Review of the PDI-SaniCloth Bleach Germicidal Disposable Wipe packing information from the PDI container listed to disinfect use wipe to remove heavy soil with a wipe, use a clean wipe to thoroughly wet surface, and treated surface must remain visibly wet for a full four minutes. Use additional wipes if needed to assure continuous 4 minute wet contact time. Then let air dry. Suggested Method of Correction The DON (Director of Nursing) or designee could review/revise facility policies to ensure proper infection control practices were followed related to disinfection of common use glucometers and educate staff on those policies. The DON or designee could perform audits to ensure the policies are being followed. Time Period for Correction 21 (twenty-one) days.	21390		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences	21535		10/2/18

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21535	Continued From page 10 which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident was reassessed for continued use of an as needed (PRN) psychotropic medication, Haloperidol (anti-psychotic), beyond the 14 days for 1 of 1 residents (R64) who received an as needed anti-psychotic medication. Findings include: R64's admission Minimum Data Set (MDS) dated 7/24/18, identified R64 was severely cognitively impaired and had diagnoses which included adjustment disorder with depression, anxiety and palliative care. The MDS indicated R64 was receiving hospice services, required extensive assistance from 2 staff with activities of daily living and required total assistance of one staff with eating. The MDS further identified R64 had no behaviors, received an anti-psychotic medication three times during the seven day	21535	Corrected.	

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21535	Continued From page 11 look-back period. R64's corresponding Care Area Assessment (CAA) dated 7/27/2018, indicated R64 was severely cognitively impaired, had end-stage heart failure and was under Hospice care due to terminal prognosis. The CAA had further indicated R64 had pain, sleep disturbances, hypoactivity, psychosocial, change in mood, symptom relief or palliative measure and restricted mobility. The CAA identified R64 received Haloperidol for agitation, restlessness and further evaluation of continued use would be completed within the next week. Review of R64's care plan dated 8/23/18, indicated R64 used an anti-psychotic medication. The care plan listed various interventions which included to consult with pharmacy and MD to consider dosage reduction when clinically appropriate. Further, the care plan indicated staff should discuss with MD and family regarding continued use of medication. Review of R64's physician progress notes and orders revealed: R64's Admission Orders dated 7/18/18, included Haloperidol 0.5 mg by mouth every 4 hours as needed for agitation and nervousness. The order further indicated the nurse was to assess use after 14 days (8/1/18). On 8/3/18, a fax was sent to the physician to address Haloperidol orders per pharmacy recommendation. Order was received from the physician via fax to continue Haloperidol 0.5 mg. by mouth every four hours as needed for agitation/ nervousness.	21535		

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21535	Continued From page 12 No further documentation was noted regarding continued use of Haloperidol. Review of R64's medication administration record from 7/18/18, to 8/23/18, revealed R64 received prn Haloperidol 8 times with the most recent date of 8/22/18. Review of Pharmacist's Monthly Drug Regimen Review Form dated 8/10/18, indicated to continue to reassess Haloperidol prn use every 14 days. Review of the pharmacy consult recommendation dated 8/10/18, indicated R64 should be reassessed for continued use of prn Haloperidol every 14 days. During observation on 8/22/18, at 07:21 a.m. R64 complained of pain to his right side of his abdomen. Registered nurse (RN)-C adminsitered Haloperidol 0.5 mg. by mouth to R64 for agitation. On 8/22/18, at 12:15 p.m. registered nurse RN-C stated an order had been received on 8/3/18 to continue the prn Haloperidol due to agitation and restlessness. RN-C verified the physician should have seen R64 within 14 days to review the continued use of the prn Haloperidol and verified the MD had not seen R64 since admission. RN-C stated the plan was for the physician to address the continued use of the prn Haloperidol on rounds that same week. On 8/23/18, at 09:07 a.m. pharmacy consultant (PC)-A confirmed prn antipsychotic medications required a rationale for use and an evaluation by a physician within 14 days for continued use. PC-A indicated pharmacy conducts monthly visits and recommendations were written in a notebook stored at the nurses station. PC-A stated	21535		

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21535	Continued From page 13 pharmacy staff advised facilities on medication dose changes and they relied on facilities to contact the physician to obtain new orders within the required 14 day timeline. On 8/23/18, at 10:17 a.m. director of nursing (DON) verified prn antipsychotic use should be evaluated by a physician within 14 days for continued use of the prn antipsychotic medication. DON stated a physician is required to see the resident in person in order to continue the medication. A facility policy titled Psychotropic Medications, revised on 7/24/18, indicated efforts to reduce dosage or discontinue of psychotropic medications will be ongoing, as appropriate, for the clinical situation. Further, the policy indicated orders for prn psychotropic medications will be time limited (times 2 weeks) and only for specific clearly documented circumstances. Suggested Method of Correction The DON (Director of Nursing) or designee could review/revise facility policies to ensure the use of as needed antipsychotic medications were monitored and rationale for use was documented and educate staff on those policies. The DON or designee could perform audits to ensure the policies are being followed. Time Period for Correction 21 (twenty-one) days.	21535		
21675	MN Rule 4658.1410 Linen Nursing home staff must handle, store, process, and transport linens so as to prevent the spread of infection according to the infection control	21675		10/2/18

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21675	Continued From page 14 program and policies as required by part 4658.0800. These laundering policies must comply with the manufacturer's instructions for the laundering equipment and products and include a wash formula addressing the time, temperature, water hardness, bleach, and final pH. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure clean facility linens were handled in a manner that prevented contamination during sorting and folding of the clean linens. This practice had the potential to affect all 86 residents served by the facility laundry. Findings include: On 8/23/18, at 10:10 a.m. during a facility laundry tour with housekeeper (HK)-A, the facility's commercial washing machines were observed. Across from the first machine, was a white Air King fan, which was mounted to the wall a few feet away. The fan's blades were encased with white fins, which were covered in a gray/white substance and had numerous fibers, up to one inch, attached to the fins and blowing in the direction of the first washer, as the fan oscillated. Above the first and second washing machines was a white, forced air vent, blowing cool air into the room. The white vent had 12 half inch fins which were covered in a black/gray film. In a separate clean room, for drying and sorting/folding, the area above the commercial dryers was observed. In the top left corner of the wall were two side by side holes through the walls that went into the next room, which housed	21675	Corrected.	

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mechanical equipment. Surrounding the entire two 6-8 inch holes, were white/gray colored fibers attached around the hole openings. Along the wall was a long sorting and folding counter, where staff were folding and sorting clean linens. Across from the counter was a white vent with seven fins blowing forced cool air directly at the counter. The white fins were covered in a black and gray film.

At 10:15 a.m. HK-A indicated the facility laundry cleaned linen for the facility including bedding and towels. She stated she had cleaned the Air King fan in the past, but could not recall when it was last cleaned. HK-A indicated she was unsure who was in charge of cleaning the forced cool air vents, or when they were last done.

At 10:38 a.m. assistant director of nursing (ADON) indicated she was in charge of infection control for the facility. ADON indicated the facility's residents, due to their age and comorbidities, were at a higher risk for infections. She stated her expectations for fans and vents blowing air onto clean linens was that they would be clean and not blow directly onto clean linen. ADON indicated if the vents and fan were not clean, there would be a potential for an infection control concern.

At 11:42 a.m. facility management (FM)-A indicated he was the supervisor for the laundry department. He indicated laundry staff would daily clean the floors and wipe things down and on Saturdays do a deep clean. FM-A indicated there was not a written list of items to be cleaned, and the cleaning was assigned to whomever was working each day. FM-A stated the Air King fan and forced air vents were not on a regular cleaning schedule. He indicated after he observed the fan today, that he would start to

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21675	Continued From page 16 have staff clean the fan weekly on Mondays. FM-A indicated the laundry staff were to make an electronic maintenance ticket if the vents were in need of cleaning. After review of the electronic maintenance ticket system, FM-A indicated no open tickets had been made to clean the vents and could not locate when the last time the vents were cleaned. A policy for cleaning in the laundry room was requested, and none were provided. SUGGESTED METHOD: The administrator or designee could develop/revise and implement policies and procedures for proper infection control measures were implemented for linen handling and educate staff on those policies. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21675		
21710	MN Rule 4658.1415 Subp. 7 Plant Housekeeping, Operation, & Maintenance Subp. 7. Hot water temperature. Hot water supplied to sinks and bathing fixtures must be maintained within a temperature range of 105 degrees Fahrenheit to115 degrees Fahrenheit at the fixtures. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an environment that was free of accident hazards related to hot water temps on 1 of 6 communities,	21710	Corrected.	10/2/18

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	00438	A. BUILDING: _____ B. WING _____	08/23/2018

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

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21710	Continued From page 17 for 16 of 16 residents (R28, R34, R15, R39, R12, R46, R85, R53, R50, R437, R54, R29, R11, R81, R74, and R56) who resided in the Timber Grove community. Findings include: On 8/20/18, at 12:49 p.m. in room 616, R11's water from the faucet in the shared resident bathroom was hot too the touch. On 8/20/18, at 1:25 p.m. in room 611, R29's water from the faucet in the shared resident bathroom was hot too the touch. On 8/20/18, at 1:26 p.m. in room 612, R15's water from the faucet in shared resident bathroom was hot too the touch. On 8/20/18, at 1:35 p.m. maintenance personnel was notified of the hot water temperatures and requested they test water temperatures on Timber Grove community. On 8/20/18, at 1:48 p.m. maintenance supervisor (MS)-A arrived on the Timber Grove community with a lap top computer. He reviewed the facility's computerized water temperature monitoring system, which he identified as "Temp Track." MS-A stated the facility had installed a new system two months ago, and would alarm if the water temperatures exceeded the parameters set in the system. MS-A thought the parameters were set at 118 degrees but would verify that with the Lead Engineer (LE). MS-A stated the first resident bathroom on the loop from the recirculating unit was room 616, and requested maintenance staff (M)-A manually test temperatures on the unit.	21710		

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21710	Continued From page 18 On /20/18, at 2:08 p.m. M-A arrived on the Timber Grove community with a facility thermometer and the following water temperatures were observed for resident bathrooms (RB). -RB 616 temperature reading was 121.2 degrees Fahrenheit (F) -RB 612 temperature reading was 121.4 degrees (F) -RB 611 temperature reading was 121.4 degrees (F) -RB 601 temperature reading was 121.5 degrees (F) On 8/20/18, at 2:12 p.m. MS-A contacted the LE via telephone, and reported the manual water temperature results. MS-A stated the LE had indicated the high end temperature parameter was currently set at 125 degrees (F). In addition, MS-A stated room 601 was the last room in the system on the Timber Grove community and stated he expected all the temperatures of hot water to be consistent on the same circulating system. MS-A requested the LE to "drop high end alarm to 118." On 8/20/18, at 2:29 p.m., during a follow up interview, MS-A stated the LE was updated with the state water temperature guidelines, and adjusted the facility high end alarm to 115 degrees (F). On 8/20/18, at 5:10 p.m. NA-A stated she was aware of 7 residents who resided on the Timber Grove Community unit and had cognitive impairment with wandering behavior. She identified R39, R50, R11, R437, R15, R74, and R46. On 8/20/18, at 5: 14 p.m. NA-E stated she was aware of several cognitively impaired residents on	21710		

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21710	Continued From page 19 the unit who wandered in and out of rooms and identified R11 and R74. On 8/20/18, at 6:45 p.m. NA-B identified R85 with cognitive impairment who wandered in and out of rooms daily, but stated there were other residents on the unit who wandered. Policy was requested on water temperature testing/environmental safety for the facility, none was provided. SUGGESTED METHOD: The administrator or designee could develop/revise and implement policies and procedures related to safe hot water temperatures and educate staff on those policies. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21710		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a dignified dining experience for 1 of 1 resident (R64) who required assistance with eating in his room.	21805	Corrected.	10/2/18

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21805	Continued From page 20 Findings include: R64's admission Minimum Data Set (MDS) dated 7/24/18, identified R64 had diagnoses which included heart failure and palliative care with Hospice services. R64's MDS further indicated R64 required extensive to total assistance of one to two staff with all activities of daily living (ADLS) and extensive assistance of one with eating. R64's care plan, revised 7/30/18, instructed staff to provide total assistance of one staff with eating due to an ADL self performance deficit related to recent physical deconditioning, infection and palliative measures. During observation on 8/20/18, at 5:56 p.m. nursing assistant (NA)-D entered R64's room with his food tray. R64 was lying in bed on his left side with bed in the low position. NA-D informed R64's supper was ready and attempted R64 to roll him to his back. R64's torso and head slumped to the left side, with his torso slightly twisted to the left side of the bed. At 6:00 p.m.,with R64 remaining in the slumped position, NA-D proceeded to lean over R64, and attempt to place upper and lower dentures in his mouth. After multiple attempts, NA-D was successful in placing both upper and lower dentures for R64. NA-D attempted to assist R64 to move his upper torso repeatedly without success. R64 remained lying in bed, with his upper torso twisted to the left, head leaning to the left, partially resting on his back. NA-D leaned over R64, raised the head of the bed, R64's body slid down in bed, with his head tilted to the left, not supported by the pillow. R64's knees and hips bent and his feet pressed on the foot board. NA-D leaned over R64 in his low bed and started to assist him to eat his meal.	21805		

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21805	Continued From page 21 R64 remained in the slumped position in bed, while NA-D continued to lean over R64 while she assisted R64 to eat bites of his meal. At 6:12 p.m., NA-D stopped assisting R64 to eat, carried a chair from across his room and sat down next to R64's bed. NA-D resumed assisting him to eat while he remained in the slouched position in bed. NA-D did not offer or attempt to reposition R64 during the meal. At 6:25 p.m., after R64 had consumed his meal, NA-D removed his meal tray and exited the room. R64 remained in the same slouched position in bed. On 8/22/18, at 12:04 p.m. NA-C stated R64's health had been declining and was in bed very frequently. NA-C indicated staff would not stand next to R64 while feeding him if he was in the dining room. NA-C indicated it is good to be at eye level with R64 when feeding. On 8/23/18, at 11:13 a.m. during a telephone interview, NA-C stated R64 required 2 staff members to reposition, and required total assistance with eating. She stated staff were expected to sit down, at eye level, while they assisted residents to eat. NA-C indicated she was unaware if she had stood over R64 while she assisted him to eat in the past. On 8/22/18, at 12:15 p.m. RN-C stated R64 should not be fed while staff stood over him. RN-C indicated staff should sit next to R64 and attempt to engage R64 in conversation while they assisted him to eat. RN-C indicated she felt it was a dignity concern for staff to stand next to R64 while assisting him to eat. On 8/23/18, at 10:17 a.m. director of nursing (DON) stated she expected staff to be seated when assisting R64 to eat while in bed.	21805		

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21805	Continued From page 22 A facility policy for dignity was requested, but not provided. SUGGESTED METHOD: The director of nursing or designee could develop/revise and implement policies and procedures for maintaining dignity with provision of cares and educate staff on those policies. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		