| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245486 | A. Building<br>B. Wing | 06/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Perham Living | 735 Third Street Southwest<br>Perham, MN 56573 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49014<br><br>Based on observation, interview and document review, the facility failed to maintain wheelchairs in a clean and sanitary manner for 1 of 2 residents (R62) whose wheelchair cushion was visibly soiled and armrests were torn. In addition, the facility failed to maintain standing lifts shared by residents in a clean and sanitary manner.<br><br>Findings include:<br><br>R62's quarterly Minimum Data Set (MDS) dated [DATE], identified R62 had moderate cognitive impairment and had diagnoses which included progressive supranuclear ophthalmoplegia (eye aim is off and can cause loss of balance), hypertension (elevated blood pressure), and osteoporosis (softening of bones). Identified R62 required substantial assistance with activities of daily living (ADLs) which included bed mobility, transfers, and toileting. Further identified R62 utilized wheelchair for mobility.<br><br>During an observation on 6/10/24 at 8:10 a.m., R62 was being walked by staff with wheelchair following. Both arm rests on R62's wheelchair were cracked and wheelchair cushion was soiled with a dry white substance.<br><br>During an observation on 6/10/24 at 8:15 a.m., two standing lifts located in the hallway cubby of the facility had brown, crumb-like debris on both foot plates.<br><br>During an observation on 6/11/24 1:45 p.m., R62 was lying in bed, both arm rests on R62's wheelchair continued to be cracked and wheelchair cushion continued to be soiled with a dry white substance.<br><br>During an observation on 06/11/24 at 1:48 p.m., two standing lifts located in the hallway cubby of facility continued to have brown, crumb-like debris present on the foot plates.<br><br>During an interview on 6/11/24 at 12:10 p.m., nursing assistant (NA)-B verified brown crumb-like particles on both standing lift footplate's. NA-B further verified R62's arm rests were both torn and wheelchair cushion was soiled. NA-B stated staff were expected to fill out a maintenance slip for wheelchair repairs. NA-B stated staff wiped lifts down with cleansing wipes after each use and there was a cleaning process and checklist for the night shift to complete. NA-B was unsure the last time the lifts or R62's wheelchair cushion had been cleaned.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 6/11/24 at 12:10 p.m., registered nurse (RN)-B verified the foot plates to both standing lifts had a brown crumb like substance present. RN-B indicated there was a handheld vacuum to clean the plates and/or cleansing wipes to wipe them down with. RN-B stated it was the night shift's responsibility to clean the lifts and wheelchair cushions. RN-B indicated it was her expectation that staff would have filled out a maintenance slip for the repair of R62's wheelchair.<br><br>During an interview on 6/11/24 at 2:22 p.m., maintenance director (MD) verified both arm rests were cracked on R62's wheelchair. MD stated his expectation was that staff would have filled out a maintenance slip so he could have replaced the arm pads to R62's wheelchair.<br><br>During an interview on 6/12/24 at 12:12 p.m., director of nursing (DON) stated nursing staff were responsible for cleaning the lifts and wheelchairs and for completing a maintenance slip for wheelchairs that required repair. DON indicated her expectation was staff would have followed the process for cleaning of equipment and repair of wheelchairs.<br><br>A facility task sheet titled Night Task Sheet undated, identified staff were to clean wheelchairs and wipe off EZ lifts and stands on Wednesdays. Further identified all staff were to wipe off EZ lifts and stands as needed.<br><br>A facility policy titled Wheelchair Repair revised 10/16/23, indicated when staff identified a wheelchair needed repair staff were to fill out a maintenance request and maintenance would have repaired the wheelchair or ordered parts if needed. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49014<br><br>Based on observation, interview and document review, the facility failed to ensure an evaluation of causal factors was completed after each fall. In addition, the facility failed to consistently develop and implement relevant interventions for 1 of 2 residents (R73) who had repeated falls in the facility and remained at high risk for falls.<br><br>Findings include:<br><br>R73's quarterly Minimum Data Set (MDS) dated [DATE], identified R73 had diagnoses which included cerebral infarction (stroke), visuospatial deficit (a term used to describe a range of cognitive impairments that affect the ability to perceive, process, and use visual and spatial information) and spatial neglect following cerebral infarction, incontinence, and hypertension (high blood pressure). Identified R73 had severe cognitive impairment and required extensive assistance with activities of daily living (ADLs), which included: bed mobility, transfers, and toileting. Indicated R73 required touching/steadying assist to complete ambulation. Identified R73 had two or more falls.<br><br>R73's Significant Change Care Area Assessment (CAA) dated 3/7/24, identified R73 had completed skilled therapies and had progressed in ADL self-care, she had been working with staff on mobility ambulating to/from bathroom and at times out of room.<br><br>R73's care plan initiated 2/4/24, identified R73 was at moderate risk for falls related to recent CVA (stroke), and decreased mobility, had cognitive impairment, required partial to moderate assistance with transfers to and from bed to chair (or wheelchair). Identified various interventions for fall prevention which included: anti-roll back applied to wheelchair, continue to intervene by having R73 seated in an area where staff could observe and intervene frequently, such as in the living room. Provide activities she enjoyed, such as wheeling to the courtyard, happy hour in the afternoon. Place wheelchair on resident right side, so can see and use it to hold onto if attempted to transfer. Wheelchair next to bed, when it bed. When in bathroom stay with resident, or stay just outside the bathroom to supervise her.<br><br>Review of R73's resident fall assessment and interview form dated 5/31/24, identified R73 had the following conditions and factors present: forgetful and was not always able to make needs known, did not use call light appropriately, severe cognitive impairment, history of falls, one to two medications that had possible side effects that could increase risk for falls, and three or more predisposing diseases: visual deficits, balance issues, cognitive condition. Form indicated R73's fall risk score was 19, identifying R73 was at high risk for falls.<br><br>Review of R73's falls incident reports and post fall analysis reports from 2/2/24 to 6/10/24, revealed the following:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - on 2/24/24, incident report identified R73 had an unwitnessed fall and was found lying on her back in the middle of her room. She appeared to have slipped out of her wheelchair. She had gripper socks on and her call light was in reach. No injuries noted and R73 was unable to give description. Identified predisposing environmental and physiological factors: lost strength/balance, slipped, gait imbalance, weakness, incontinence, and impaired memory.<br><br>- on 2/24/25, post fall analysis identified R73 had an unwitnessed fall in her room. It appeared R73 slipped out of her wheelchair, gripper socks on and call light was in reach. Identified R73 risk factors increasing fall risk: 14 (moderate risk), no falls since admission. Diagnoses identified visuospatial deficit, stroke, and high blood pressure. Identified R73 was forgetful and did not utilize call light, struggled with making her needs known. Identified root cause of R73 not remembering to use call light and attempted to self transfer. Identified intervention of continuing current fall interventions and PT to evaluate and treat as ordered or as needed (PRN).<br><br>- on 3/22/24, incident report identified R73 had an unwitnessed fall and was found seated next to her bed, on her bottom, attempting to undress her undergarments. R73 was in a night gown, sleeping in per her usual, had both gripper socks on, shoes over, and wheelchair within reach of her bed. Her call light was also on her bed within reach. She was incontinent of urine in her brief, it appeared she was attempting to reach the toilet. No injuries noted and R73 unable to give description. Identified predisposing situation factor of ambulating without assist, but no predisposing environmental or physiological factors listed.<br><br>- on 3/22/24, post fall analysis identified R73 had an unwitnessed fall and was found seated next to her bed on her bottom, attempting to undress undergarments. Gripper socks on, shoes, wheelchair and call light in reach. R73 was incontinent of urine. Identified risk factors increasing fall risk: 19 (high risk), with previous history of fall on 2/24/24. Diagnoses of visuospatial deficit, stroke, and high blood pressure. Identified root cause of R73 not remembering to use call light and attempted to self transfer. Identified therapies were completed on 2/29/24, and was unable to progress further due to short and shuffled gait pattern, and dependence on staff for steering her walker.<br><br>- on 3/30/24, incident reported identified R73 had an unwitnessed fall and was found seated on the floor in her room, next to her bed. Back against the side of her bed with legs in front of her. R73 was not wearing any pants or brief. The pants and brief were next to her, brief was wet. Appeared she stood up, took off the brief and pants and then sat back down on the floor. No injuries noted and R73 unable to give description. Identified predisposing physiological and situation factors of incontinent, gait imbalance, and ambulating without assist.<br><br>- on 3/30/24 at 755 a.m., post-fall analysis identified R73 was found seated on the floor in her room, next to her bed. Back against the side of her bed with legs in front of her. R73 was not wearing any pants or brief. The pants and brief were next to her, brief was wet. Appeared she stood up, took off the brief and pants and then sat down on the floor. The report revealed no injuries, no pain. Identified risk factors increasing fall risk: fall risk score of 19 (high risk), previous history of falls on 3/22/24, and diagnoses of visuospatial deficit and spatial neglect, stroke, and high blood pressure. Identified root cause: impulsive at times and doesn't always remember to use call. Appeared to have been incontinent and took off wet brief, had poor vision and left sided weakness related to stroke. Wheelchair was not in reach. Identified placing wheelchair next to bed as intervention.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - on 4/19/24, incident report identified R73 had an unwitnessed fall and resident had slipped out of her wheelchair onto the floor. Upon entering pine harbor writer found R73 on the floor on her buttocks with her back against her wheelchair and her legs straight out in front of her. she was wearing shoes. No injuries noted and R73 unable to give description. Identified predisposing environmental, physiological, and situation factors: lost strength, slipped, gait imbalance, impaired memory, weakness/fainted, ambulating without assist and during transfer.<br><br>-on 4/19/24 at 2:30 p.m., post-fall analysis identified R73 had slipped out of her wheelchair onto the floor. Upon entering Pine Harbor writer found R73 on the floor on her buttocks with her back against her wheelchair and her legs straight out in front of her. She was wearing shoes. Identified no injuries. Identified risk factors increasing fall risk: fall risk score of 19 (high risk), previous history of falls, diagnoses visuospatial deficit and spatial neglect, CVA (stroke), high blood pressure. She spoke fluent Spanish and staff utilized an interpreter to communicate. She was forgetful and did not utilize her call light and struggled with making her needs known. Root cause identified: was scooting in her wheelchair and scooted out onto her buttocks. Intervention identified as review information on past falls and attempt to determine cause of falls. Record possible root causes.<br><br>-on 4/28/24 at 12:30 p.m., incident report identified R73 had an unwitnessed fall. Trained medication aide (TMA) notified nurse that resident had fallen. When writer got to resident, resident was already off the floor and seated in her wheelchair. TMA explained that resident was using the bathroom and the aide stepped just outside of the door for just a couple minutes to give her a little privacy, as she was having a bowel movement, and when she went back in just a couple minutes later resident was found on the floor in front of the toilet and attempted to get herself off the floor using the hand rails. No injuries noted and R73 unable to give description. Identified predisposing physiological factors: gait imbalance, impaired memory. No environmental or situation factors identified. Identified staying in bathroom with R73 or just outside of the bathroom to supervise.<br><br>- on 4/29/24 at 2:04 p.m., post fall analysis identified R73 fell in bathroom after having a bowel movement, staff left R73 alone to provide privacy. R73 attempted to get off the floor using the hand rails. Identified risk factors increasing fall risk: fall risk score 19 (high risk), previous history of falls, diagnoses visuospatial deficit, CVA (stroke), high blood pressure. R73 spoke fluent Spanish and staff utilized interpreter for communication. R73 was forgetful and is not always able to make needs known and did not use call light appropriately. R73 was impulsive at times and did not use call light.<br><br>-on 5/13/24, incident report identified R73 had an unwitnessed fall. R73 had self transferred into bed and had a bloody nose. R73 indicated that she bumped her nose on the side rail of the bed. No other injuries noted. Identified predisposing environmental, physiological, and situation factors: other, gait imbalance, and ambulating without assist.<br><br>Review of R73's medical record lacked evidence of a post fall risk analysis for R73's fall on 5/13/24.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -on 5/20/24, incident report identified R73 had an unwitnessed fall. R73 was found seated next to bed on the floor with her pants down. It appeared as if she was attempting to walk to the bathroom, back was resting against side table. No injuries noted. R73 stated she did not hit her head and was not dizzy, but she did have a headache. She did not complain of any other pain, resident stated she was trying to get to the bathroom. Identified predisposing environmental and physiological factors: poor lighting, lost balance, confused, gait imbalance, and weakness/fainted.<br><br>- on 5/20/24 at 9:45 a.m., post fall analysis identified R73 was found sitting next to bed on the floor with her pants down attempting to find the bathroom. Translator was contacted through her iPad to have a better understanding of what happened, R73 stated she did not hit her head, but she does have a headache. R73 did not complain of any other pain and stated was trying to get to the bathroom. Identified risk factors increasing fall risk: fall risk score of 19 (high risk), previous history of falls, diagnoses visuospatial deficit and spatial neglect, CVA (stroke), high blood pressure. She spoke fluent Spanish and staff utilized an interpreter to communicate. R73 was forgetful and did not utilize her call light and struggled with making her needs known. Identified cause of fall R73 was impulsive at times and did not utilize call light. R73 was self transferring to get to bathroom. Identified intervention of moving call light closer to R73, on her when in bed. Check in on her around 7:30 a.m. to see if she needs to use the bathroom.<br><br>- on 5/25/24 at 8:00 p.m., post fall analysis identified R73 was found sitting on floor between wheelchair and couch, with back resting against couch. No injuries noted. Identified risk factors increasing fall risk: fall risk score 19 (high risk), history of falls with last fall on 5/20/24. Diagnoses of visuospatial deficit, stroke, high blood pressure. Cognitive functioning identified R73 as forgetful, was not always able to make needs known and did not use call light appropriately. Identified root cause of R73 attempted to self transfer from wheelchair to couch. Identified intervention of having R73 sit in an area where staff could observe and intervene frequently.<br><br>-on 5/29/24, incident report identified R73 had an unwitnessed fall. R73 was found sitting on floor between wheelchair and couch, with back resting against couch. No injuries noted and R73 was unable to give description. Identified R73 had increase in confusion since family visited earlier in the day, had been looking for family to return home with them. Identified predisposing environmental, physiological, and situation factors: slipped, confused, gait imbalance, impaired memory, and during transfer.<br><br>- on 6/10/24 at 3:36 p.m., post fall analysis identified R73 had a fall and was found lying on her left side holding onto her call light. R73 indicated she did not hit her head and was trying to get up, no injuries. Identified risk factors increasing fall risk: fall risk score of 19 (high risk), previous history of falls, diagnoses of visuospatial deficit, stroke, and high blood pressure. R73 spoke fluent Spanish and an interpreter was utilized for communication. R73 was forgetful and was not always able to make needs known, did not use call light appropriately. Identified root cause of R73's fall as self transfer attempt. Identified interventions of continuing with current interventions at this time.<br><br>Review of R73's medical record lacked evidence of an incident report for R73's fall on 6/10/24.<br><br>Review of R73's progress note dated 6/10/24 at 3:34 p.m., identified R73 had a fall and was found lying on her left side holding her call light. R73 indicated she was trying to get up and stated she did not hit her head. No injuries noted.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 06/11/24 at 1:33 p.m., R73 was observed sitting in living room recliner, wheelchair was approximately ten feet from R73 in front of fire place. No staff were observed to be present in the living room at the time.<br><br>During an observation on 06/11/24 at 2:24 p.m., R73 continued to be sitting in living room recliner wheelchair continued to be approximately 10 feet away from R73 in front of the fire place.<br><br>During an observation on 06/11/24 at 4:47 p.m., R73 was observed lying on her back in bed with wheelchair approximately 8 feet away. R73 was restless and calling out for help. R73 grabbed U shaped rail on bed with both hands and sat up independently to side of bed with legs dangling.<br><br>During a joint interview on 6/11/24 at 4:51 p.m., registered nurse (RN)-A and nursing assistant (NA)-C verified R73 was sitting up at the edge of her bed with wheelchair approximately 8 feet away. RN-A indicated she was unaware of R73's care plan interventions and would need to refer to her chart to find fall interventions. NA-C stated R73's care plan fall intervention was for wheelchair to be positioned next to her bed and next to the recliner in living room.<br><br>During an interview on 6/12/24 at 08:21 a.m., clinical manager (CM)-A verified R73 was a high fall risk and had multiple falls at the facility. CM-A verified care plan fall interventions and stated her expectation was staff would have followed care planned fall interventions. CM-A confirmed the facility had not completed a post fall analysis after the 5/13/24, fall to determine the cause of the fall and to develop or revise interventions to prevent future falls.<br><br>During an interview on 6/12/24 at 12:19 p.m., director of nursing (DON) verified R73 was a high fall risk and had multiple falls at the facility. DON stated her expectations was that staff would have followed care plan interventions to prevent falls.<br><br>Review of a facility policy titled Fall Protocol reviewed 1/8/24, identified that a post-fall huddle would be initiated after each fall to gather pertinent information. The charge nurse would update the individualized care plan and care card with post-fall interventions and would communicate changes to staff in regards to the updated plan of care. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37905<br><br>Based on observation, interview and document review, the facility failed to implement appropriate donning/doffing of personal protective equipment (PPE) practices and to ensure PPE was readily available for use to prevent the spread of infection for 4 of 4 residents (R14, R3, R33, R58) observed for enhanced barrier precautions (an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities). In addition, the facility failed to ensure personal laundry was transported and delivered in a manner that prevented risk of contamination for 1 of 6 units observed for personal laundry transportation.<br><br>Findings include:<br><br>Review of Centers for Disease Control (CDC) guidance dated 4/1/24, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) indicated Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions (EBP) included: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator and wound care: any skin opening requiring a dressing.<br><br>R14<br><br>R14's quarterly Minimum Data Set (MDS) dated [DATE], identified R14 was cognitively intact and had diagnoses which included: diabetes mellitus, obstructive uropathy (disorder of urinary tract that obstructs urinary flow) and urinary tract infection. Indicated R14 had an indwelling urinary catheter.<br><br>R14's care plan revised 4/25/24, identified R14 had a suprapubic catheter (a urinary catheter that drained urine from the bladder through a small incision in abdomen) secondary to benign prostatic hyperplasia (enlarged prostate) (BPH) with urinary retention and urinary obstruction. R14's care plan lacked EBP interventions to be used related to R14's indwelling device, the suprapubic catheter.<br><br>R14's Order Summary Report dated 6/12/24, identified the following:<br><br>-Suprapubic catheter change -20 french (F) Council Tip 5 cubic centimeters (cc) balloon: use 10 cc sterile water in balloon. One time a day every 28 day(s).<br><br>During an observation and interview on 6/10/24 at 8:06 a.m., R14's room lacked signage of EBP and PPE was not available inside or outside R14's room. R14 confirmed he had a catheter and indicated staff wore gloves when caring for his catheter however, did not wear gowns.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 6/11/24 at 2:39 p.m., R14 placed his call light on in his room and stated he needed to have his catheter emptied. R14's room continued to lack signage of EBP and PPE was not available inside or outside R14's room. At 2:42 p.m. nursing assistant (NA)-A knocked and entered R14's room and R14 asked to have his catheter bag emptied. NA-A applied gloves and gathered equipment of a graduate (plastic container used to measure liquids), paper towel and alcohol wipes. NA-A placed the paper towel on the floor next to R14's left foot and placed the graduate on the paper towel. NA-A opened an alcohol wipe and placed that on the paper towel next to the graduate. NA-A opened R14's catheter bag, drained the urine into the graduate, clamped the tubing, wiped the opening with alcohol, closed the tubing, went to the bathroom and emptied the urine into the toilet. NA-A returned to R14 and repeated the process to finish emptying the urinary catheter. NA-A disposed of the paper towel, emptied the graduate, rinsed the graduate, removed her gloves and completed hand hygiene. NA-A did not wear a gown during the high contact activity of emptying R14's urinary catheter.<br><br>During an interview on 6/11/24 at 2:48 p.m., NA-A stated was unaware of what EBP was, and indicated had not been instructed to wear a gown when accessing R14's catheter or completing high contact resident care activities.<br><br>48583<br><br>R3<br><br>R3's quarterly MDS dated [DATE], identified R3 was cognitively intact and had diagnoses which included: diabetes mellitus, cancer, peripheral vascular disease (a condition where narrowed blood vessels outside the heart cannot deliver sufficient oxygen and nutrients to the body) and neurogenic bladder (the nervous system and bladder function is disrupted by injury or disease). Indicated R3 had open pressure ulcers to both feet and an opening draining wound on right foot.<br><br>R3's care plan revised 6/7/24, identified R3 had a recent surgical procedure (transmetatarsal amputation of the right foot), was partial weight bearing on right foot and was required to wear a Prevalon boot to right foot along with a [NAME] boot to left foot. R3 had activities of daily living deficits secondary to weakness. R3 required maximum assistance of one to dress and undress below the waist, transferring on and off the toilet, washing back side and adjusting clothing.<br><br>During an observation on 6/10/24 at 1:16 p.m., NA-F was observed assisting R3 out of the bathroom after resident had placed his call light on for assistance. When entering the room, NA-F assisted R3 from toilet to wheelchair in bathroom. NA-F was not wearing gloves or a gown during R3's transfer. NA-F pushed R3 out of the bathroom into his room in his wheelchair. R3 was wearing a white stocking under a Prevalon boot to right foot. [NAME] stocking had visible red discoloration that was coming from underneath the stocking towards the end of R3's right foot. NA-F picked up R3's right foot and helped place it on the right foot pedal of the R3's wheelchair. NA-F was not wearing any gloves or gown while assisting with R3's foot placement. NA-F asked R3 if there was anything else that R3 needed and R3 declined any additional needs or assistance. NA-F exited R3's room, walked across the hallway and entered another resident's room to provide assistance. NA-F was not observed to wash her hands or use any hand sanitizer when leaving R3's room or entering another resident's room.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245486 | A. Building<br>B. Wing | 06/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Perham Living | 735 Third Street Southwest<br>Perham, MN 56573 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 6/12/24 at 2:02 p.m., NA-F confirmed she assisted R3 in the bathroom with adjusting his pants and assisted R3 to transfer to R3's wheelchair. In addition, NA-F confirmed she placed R3's leg onto his wheelchair foot pedal without wearing a gloves or a gown. NA-F indicated she was not aware she needed to wear any EBP items when assisting R3. NA-F stated she was aware of the cart in R3's room containing EBP PPE in R3's room however was not aware why it was in there or what she was expected to do with it. NA-F stated she read the policy on EBP on her own while working to educate herself on the facility's expectations and guidelines however had not received any formal training on EBP.<br><br>49620<br><br>R33<br><br>R33's quarterly MDS dated [DATE], identified R33 was cognitively intact and had diagnoses which included: diabetes mellitus, chronic kidney disease stage five, end stage renal disease, dependence on renal dialysis. Indicated R33 had a central port.<br><br>R33's care plan revised 8/25/20, identified R33 had a central line dialysis access to the right side of chest. A central venous catheter (CVC) is a type of access used for hemodialysis. Tunneled CVC's are placed under the skin and into a large central vein. Dialysis (a blood purifying treatment given when kidney function is not optimum). R33's care plan lacked enhanced barrier precautions (EBP) interventions to be used related to R33's indwelling devise, the central venous catheter.<br><br>R33's Order Summary Report dated 5/21/24, identified the following:<br><br>-Dressing change to central line right sided chest wall as needed. Change if dressing was not intact. Was routinely changed at dialysis.<br><br>R58<br><br>R58's quarterly MDS dated [DATE], identified R58 was cognitively intact and had diagnoses which included: venous stasis ulcers to bilateral lower extremities (wounds that develop because of problems with blood circulation) and urinary retention (disorder of urinary tract that obstructs urinary flow). Indicated R58 had an indwelling urinary catheter.<br><br>R58's care plan revised 4/07/24, identified R58 had an indwelling foley catheter (a urinary catheter that drained urine from the bladder inserted through the penis) secondary to urinary retention. R58's care plan revised 6/5/24, identified R58 had venous stasis ulcers. Treatment and dressing change as ordered. R58's care plan lacked EBP interventions to be used related to R58's indwelling device, the indwelling foley catheter and venous ulcer wounds to bilateral feet.<br><br>R58's Order Summary Report dated 5/30/24, identified the following:<br><br>-Apply betadine to right lateral foot sore, cover with telfa and kerlix gauze, one time a day.<br><br>-Iodine topical solution apply to bilateral foot ulcers one time a day.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R58's Order Summary Report dated 5/30/24, lacked documentation for care of the urinary foley catheter.<br><br>During an observation and interview on 6/10/24 at 1:22 p.m., R33 confirmed he had a CVC used for dialysis. R33 stated he returned from dialysis today and the EBP bins and a sign on the inside of his door were placed in his room while he was at dialysis. R33 stated staff informed him they would now wear gowns and gloves when completing cares. R33 confirmed the facility staff had not been using gowns and gloves prior to that time.<br><br>During an observation and interview on 6/11/24 at 6:39 p.m., R58 confirmed he had a foley catheter and wounds present on both feet. R58 stated the EBP bins and sign on the inside of his door in his room were placed a few days ago and he had been informed by staff they would start to wear gowns and gloves when completing cares.<br><br>During an interview on 6/12/24 at 1:05 p.m., NA-E stated she was unsure when EBP were initiated for R33 and R58. NA-E asked clinical manager-B who verified EBP were initiated on 6/10/24, for R33 and R58.<br><br>During an interview on 6/12/24 at 1:24 p.m., licensed practical nurse (LPN)-A stated EBP were initiated within the past week for R33 and R58. LPN-A stated EBP for all residents that required EBP would not go into effect until July sometime.<br><br>49014<br><br>LAUNDRY<br><br>During an observation on 6/11/24 at 1:50 p.m., NA-B carried and delivered two shirts on hangers to R279's room and had clean laundry under both arms pressed against her uniform and delivered these laundry items to R73's room.<br><br>During an interview on 6/11/24 at 1:54 p.m., NA-B verified she held clean laundry items against her uniform. NA-B stated the normal process was to deliver clean laundry to rooms in baskets and carry it away from the body to prevent cross contamination. NA-B stated she should have placed the clean laundry in baskets to deliver to R279 and R73.<br><br>During an interview on 6/11/24 at 4:34 p.m., director of nursing (DON) confirmed the facility had not implemented EBP procedures and planned to implement them on 7/1/24. DON indicated they had a family council meeting to inform them of EBP procedures and stated the family members were not happy about it. DON stated they had started education on EBP implementation however, not all staff had received education at that time and not every resident who required EBP had PPE supplies for their rooms.<br><br>During a follow-up interview on 6/12/24 at 12:12 p.m., DON stated her expectations of transporting clean laundry was that staff would have carried clothing items in baskets, covered them with a cloth/towel or delivered them on the covered linen carts. DON further stated staff should not have held clean laundry against their uniform to prevent the spread of infection.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 6/12/24 at 1:04 p.m., registered nurse infection preventionist (IP)-A confirmed she had been aware of EBP and had first received information about EBP on 7/22. IP-A stated Centers for Medicare & Medicaid Services (CMS) had sent out QSO 24-08 Enhanced Barrier Precautions In Nursing Homes To Prevent The Spread Of Multidrug-Resistant Organisms (MDROs) dated 3/20/24, which she referred to, and confirmed the effective date for implementation was 4/1/24. In addition, IP-A referred to the CMS survey pathway for Infection Prevention, Control & Immunizations, and stated that was available on 4/1/24. IP-A confirmed the facility had not implemented EBP yet at the facility and were in the process of working on it. IP-A verified residents who required EBP included those identified with MDROs' colonized or not, anyone with indwelling devices and wounds such as diabetic wounds and pressure ulcers. IP-A confirmed R14 had an indwelling device, a suprapubic catheter.<br><br>The untitled, undated facility form provided by the facility identified columns which included: Resident Name, Unit Name, MDRO, MDRO, and Concerns. The column of resident names identified some of the residents as (does not meet criteria) under the resident's name. The residents identified on the form who did not have (does not meet criteria) under their name, included the following:<br><br>-Pine Harbor-one resident,concern: ostomy<br><br>-Harvest Glen-two residents-concerns: suprapubic catheter in place, and indwelling catheter<br><br>-Timbergrove-two residents-concerns: G-tube present with water flushes, and indwelling catheter<br><br>-[NAME]-four residents-concerns: central port dialysis catheter in place, ostomy, indwelling catheter, daily antibiotics, and indwelling catheter with wounds to lower extremity (LE)<br><br>-Prairie [NAME]-one resident-concern: hemodialysis catheter<br><br>-Transitions-two residents-concerns: multiple wounds to LE, open wounds to toes, wound vac on his stump post-op (following surgery)<br><br>The facility policy titled Enhanced Barrier Precautions (EBP) undated, identified it was intended to prevent the transmission of drug resistant pathogens. The policy identified EBP included the use of PPE, specifically gowns and gloves during high contact activities for residents. High contact activities were defined as dressing/bathing, transferring, changing linens, assisting with toileting, accessing indwelling medical devises, providing wound care, and other activities that provide opportunities for transfer of MDROs to staff hands and clothing. An indwelling medical devise included central lines, PICC lines (line inserted into vein in arm that passed to larger veins near the heart), urinary catheters, and feeding tubes.<br><br>Review of a facility policy titled Linens: Collecting, Sorting, Transport & Storage reviewed 6/2020, identified package, transport and store clean textiles and fabrics by methods that will ensure their cleanliness and protect them from dust and soil during loading, transport and unloading. Further identified Clean linens shall be transported to patient/resident care areas by use of covered carts by hospital or nursing home staff. |