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	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perham Living	735 Third Street Southwest 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure clinical justification and behavior monitoring for the use of an antipsychotic medication for 1 of 1 resident (R2) reviewed who was on a psychotropic medication. Findings include:R2's significant change Minimum Data Set (MDS) dated [DATE], identified R2 had intact cognition and was dependent on staff for activities of daily living (ADLs). R2 had not exhibited any behavioral symptoms. Diagnoses included Parkinson's disease, paraplegia, dysfunction of bladder, cardiomyopathy, dysphagia, hallucinations, and unspecified mental disorder due to known physiological condition. R2's Physician Progress Note for Nursing Home Visit dated 2/5/26, identified R2 was being seen by R2's primary care provider (PCP)-A for gastrointestinal concerns and tremors. The assessment/plan was identified as splenic infarct-ultrasound of abdomen complete, anemia- complete blood count with differential, hallucinations - quetiapine (Seroquel) 25 milligrams (mg) one time per day, and gastroesophageal reflux disease- omeprazole 20 mg one time per day. The plan identified R2 would resume Seroquel 25 mg per day as it had seemed R2 was better on the medication. A complete blood count (CBC) was ordered and a scheduled ultrasound. After the visit, an abnormal CBC and hemoglobin was identified and R2 was sent to the emergency department for further evaluation. Although R2 PCP-A restarted the Seroquel there was no identification of new onset of symptoms warranting the antipsychotic medication.R2's Psychotropic Medication Use Care Area Summary (CAA) dated 2/27/26, identified R2 was restarted on an antipsychotic medication by PCP-A for increased tremors. R2 had a history of hallucinations, and his PCP indicated his mental status seemed to be better when on the antipsychotic medication. The summary indicated the care plan reflected interventions to remain free from adverse effects of the antipsychotic medication and R2 would maintain relief from hallucinations and tremors. Staff were to monitor for side effects per protocol and update the PCP with any concerns. The CAA indicated target symptoms were noted in plan of care with non-pharmacological interventions.R2's care plan dated 3/5/26, identified R2 was administered the psychotropic medication Seroquel related to hallucinations. Staff were directed to administer the medication as ordered, consult with pharmacy and PCP to consider dose reduction when appropriate, educate resident and family about the risks, benefits and side effects and/or toxic symptoms of the drug being given and discuss with PCP and family regarding the ongoing need for the use of the medication. Staff were also directed to monitor and record occurrences of targeted behaviors symptoms, which included disrobing, inappropriate response to verbal communication, attempts to reach items that were not present and decrease hallucinations or delusional ideations and document. However, there were no non-pharmacologic approaches and interventions related to the target behaviors being monitored.R2's most recent Physician Order Report dated 3/24/26, identified quetiapine fumarate (Seroquel) 25 milligrams (mg) to be given one time per day related to hallucinations, with a start date 2/9/26. On 3/23/26, at 7:12 p.m. R2 was observed being wheeled into his room by his spouse. R2 stated he had just returned from a physician appointment and then a visit with his wife at his home. R2 stated he had lost some weight recently but was stabilizing. R2 had been in the hospital recently (continued on next page)

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with a very bad urinary tract infection and had been on four different antibiotics. R2 stated the antibiotics had messed with his stomach and so he was not eating well. R2 was fully dressed and groomed. R2's left arm was hanging down over the wheelchair arm, with hand towards floor. R2 was eventually able to lift his arm up and over the arm of the wheelchair. Both of R2's hands were lightly closed and had difficulty moving his arms easily. No significant tremor was noted during the conversation. R2 answered questions appropriately and clearly. R2's nursing progress notes 11/1/25 to 3/23/26, identified the following:-12/5/25, R2 was a little bit confused as he answered football to questions two times. When further questioned, R2 answered all questions to person, time and place correctly. Staff would continue to monitor.-12/6/25, R2 went into urgent care for increase confusion and decrease urinary output. Returned with treatment ordered for a urinary tract infection. -1/5/26, R2 was seen on routine doctor rounds. It was noted R2 had been using his as needed (PRN) carbidopa/levodopa (a medication to treat Parkinson's disease) since around 12/10/25, for increase tremors, would try to stop that PRN medication and see how it went. -2/5/26, R2 had an upcoming appointment with his PCP that day for acute issues of upset stomach, decreased appetite, with question if should go back on omeprazole (to treat excess stomach acid), R2's weight was down. R2 had increased tremors with question to discuss going back on Seroquel. -2/5/26, R2 was seen in the clinic for a follow up visit on abdominal symptoms and start of anticoagulation related to splenic infarction. Omeprazole and Seroquel were ordered. A CBC was ordered to be drawn that day, an ultrasound scheduled and speech therapy ordered. R2's medical record lacked any behavioral monitoring or evidence of R2 having any hallucinations, delusional thoughts, inappropriate communication or removing his clothing, prior to the restarting of the Seroquel.During interview on 3/24/26, at 3:29 p.m. registered nurse (RN)-B stated she helped manage psychotropic medications in the facility including managing orders and physician follow up. RN-B was aware R2 was on Seroquel and then they had tapered the medication down and stopped the medication in December 2025. RN-B stated R2 had hallucinations of water dripping on him and getting him wet, which distressed him. R2 reported his hallucinations to his spouse. RN-B was aware R2's Seroquel was restarted and then he went to the hospital and was still on the medication upon his hospital return. RN-B stated R2 did have targeted behaviors that were care planned, which included disrobing, inappropriate response to communication, attempt to reach for objects not present and hallucinations. RN-B stated there should be some type of behavior monitoring or staff should chart if there were any behaviors present. RN-B reviewed R2's medical record and stated she was unable to find any behaviors documented for R2. During interview on 3/24/26, at 3:46 p.m. RN-A stated staff and R2's spouse had been noting an increase in R2's tremors since his Seroquel had been stopped. RN-A thought R2 had been using his PRN carbidopa/levodopa more frequently, nearly daily since the Seroquel had been stopped. She had addressed the increase tremors with R2's PCP, and he had restarted the Seroquel. RN-A was sure there was weekly psychotropic medication monitoring for side effects but was unable to find any documentation of targeted behaviors such as hallucinations. RN-A thought the spouse had reported the behaviors, but it had not been documented. During telephone interview on 3/24/26, at 4:36 p.m. PCP-A stated he did not think he would have stated he was restarting R2's Seroquel for increase tremors, as increase tremors was not an indication of use for that medication. PCP-A would never prescribe any medications for treatment of R2 symptoms related to his Parkinson's disease, as R2 was being seen by a neurologist for his Parkinson's symptoms. PCP-A stated it had seemed R2 was mentally better when he was on the Seroquel and the medication was prescribed at a low dose. PCP-A stated he did restart the Seroquel before his labs came back that identified an infection and R2 was hospitalized . PCP-A stated he would have treated the infection first before restarting the Seroquel. The facility policy Psychotropic Medications date 3/10/26, identified physicians and mid-level providers would use psychotropic medications appropriately working with the interdisciplinary team to ensure appropriate use, evaluation and monitoring. The facility would support the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	environmental, medical, and/or behavioral interventions, as well as psychopharmacological medications could be utilized to meet the needs of the individual resident. Nursing would monitor for the presence of identified behaviors by charting occurrence and using behavior template. Nursing would review the use of the medication with the physician on a quarterly basis to determine the continued presence of targe behaviors and/or the presence of any adverse effects of the medication use.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions following a fall to reduce the risk of falls for 1 of 3 residents (R1) reviewed for accidents. Findings include: R1's Fall Assessment and Interview dated 3/5/36, identified R1 had falls during the last month, as well as in the last two-to-six-month period. R1 took diuretic, hypoglycemic, antiseizure, non-steroid anti-inflammatory and cathartic medications. R1 had good memory, and vision and was continent of bowel and bladder. No behavior was identified and R1 used an assistive device with ambulation. R1's risk score was six which represented a moderate risk for falls. R1's significant change Minimum Data Set (MDS) dated [DATE], identified R1 had intact cognition and was independent with activities of daily living. R1 was continent of bladder and had a colostomy. R1 had occasional complaints of pain. Diagnoses included congestive heart failure, heart disease, diabetes, Parkinson's disease, dementia and use of hypoglycemic medications. R1's progress note dated 3/15/26, identified R1 had placed his call light on. R1 was found lying in bed and reported to staff he had fallen. A skin tear was noted on his right elbow and bruising noted to his left inner upper arm. R1 stated he did not call staff as he thought he could do it himself, however, the note did not identify what it was R1 had been trying to do. Later, R1 complained his bottom hurt. R1's care plan dated 3/18/26, identified R1 was at risk for falls related to Parkinson's symptoms with impaired balance. Staff were directed to anticipate and meet his needs; be sure his call light was within his reach and encourage R1 to use the call light for assistance when needed. Staff were directed to promptly respond to all requests for assistance. Staff were to educate R1 and family about safety reminders and what to do if a fall occurred, encourage R1 to change positions slowly, ask for assistance when walking off the unit when needed and encourage to call if a fall occurred. Staff were to ensure R1 was wearing appropriate footwear with ambulation, and monitor blood glucose and sleepiness to see if other symptoms developed. R1 had a necklace style pendant to use for emergencies when he needed staff assistance. The most recent interventions had been added on 2/5/26. R1's physician progress note dated 3/20/26, identified R1 was seen by his primary physician (PCP)-C. R1 complained of persistent pain in his buttocks following a fall that had occurred two days previously. No open wounds or fractures were reported, and the discomfort was being managed with acetaminophen as needed. R1 also reported ongoing bilateral lower back pain that had begun after his recent fall. Pain was localized to the lower back. R1's mobility was maintained but R1 had continued complaints of muscle pain and repeated falls, which were attributed to weakness and deconditioning. acetaminophen did provide relief and R1 was considering Aspercreme for additional pain management. The assessment and plan identified R1 complained of back pain, possibly from frequent falls. PCP-C examined R1 and noted the pain appeared to be at the level of lumbar five, in the middle, but no deformities were noted. PCP-C ordered Aspercreme and to work with physical therapy. R1's medical record lacked evidence the fall on 3/15/26 was assessed for potential factors that may result in a fall including but not limited to: Environmental hazards, such as wet floors, poor lighting, incorrect bed height and/or width, or improperly fitted or maintained wheelchairs; Unsafe or absent footwear and loose or improperly worn clothing; Underlying chronic medical conditions, such as arthritis, heart failure, anemia and neurological disorders; Acute change in condition such as fever, infection, delirium; Medication side effects; Orthostatic hypotension; Lower extremity weakness; Balance disorders; Poor grip strength;, Functional impairments (difficulty rising from a chair, getting on or off toilet, etc.); Gait disorders; Cognitive impairment; Visual deficits; Pain; and Incontinence.; along with an analysis and interventions, if warranted, to reduce the incidents of future falls. On 3/23/26, at 2:18 p.m. R1 was observed just getting up to a sitting position on the side of his bed. R1 stated he had fallen the week previous in his room and had hurt his back. R1 was not sure why or how he fell. R1 stated he had just (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been walking across his room and fell. R1 stated he had then got himself up off the floor and proceeded to the bathroom, where he experienced another fall. R1 stated his back really hurt. On 3/23/26, at 5:37 p.m. The door to R1's room was partially open and R1 was observed getting up to a sitting position on the side of his bed. R1 was barefoot. R1 stated his back was really hurting from a fall that had occurred a few days ago. When interviewed on 3/24/26, at 11:49 a.m. nursing assistant (NA)-A stated R1 was independent with all of his care. The staff did not do anything for R1 except for on his bath day, which they help him with. R1 did have falls in the past but had not had any recent falls that she was aware of. R1 did spend a lot of time in his room with the door closed, and there were times NA-A would try to prop his door open but then R1 would get up and close it. The staff did not check on R1 at all, but he would ring his call light if he needed anything. R1 was pretty independent. During interview on 3/24/26, at 12:03 p.m. registered nurse (RN)-C stated the charge nurse on duty who discovered a resident had fallen would try to figure out what had occurred and report to the unit manager who would then update the care plan if any new interventions were added. RN-C was not sure why R1's last fall did not have a post fall analysis completed and would need to ask the unit manager. When interviewed on 3/24/26, at 12:15 p.m. RN-A stated R1's last fall of 2/27/26 and it was reviewed at the facility's interdisciplinary fall team (fall IDT) meeting that met weekly. A new intervention was added to offer R1 a snack when he was visiting with his spouse on another unit. RN-A was aware R1 had fallen the week previously as she had just noticed it documented in the nurse progress notes. RN-A planned to follow up with the nurse that discovered the fall and have her put in a post fall analysis report under the assessment tab as well record it in risk management. The weekly fall IDT team reviewed risk management for all the falls that had occurred. The IDT team did not review R1's fall when they met on 3/18/26, because it had not been recorded in risk management and so they were not aware a fall had occurred. RN-A stated she planned to have IDT discuss the fall during the current week meeting. RN-A stated an analysis of R1's fall had not been completed because the nurse that discovered the fall did not complete all the required steps for recording the occurrence and did not follow the facility's fall procedures. On 3/24/25, at 3:05 p.m. the assistant administrator stated the facility did weekly fall meetings and AA-C felt the team went over resident falls pretty thoroughly. AA-C would expect staff to document resident falls objectively and put all the information into the documentation to obtain the correct interventions, in order to keep residents safe. During interview on 3/24/26, at 3:15 p.m. the assistant director of nursing (ADON)-D stated when a resident fell, an email notification went out to the registered nurse case manager group to notify them of the fall. The fall IDT obtained resident fall information by reviewing the post fall analysis forms that were completed any time a resident had a fall. ADON-D would have expected the RN case manager to follow up on a note that was documented in a resident chart regarding a fall. If a post fall analysis form had not been completed following a resident fall, then the facility's fall procedure had not been followed and as a consequence, the fall IDT group would not have reviewed the fall to try to determine the root cause of the fall and/or identify any interventions that could have been attempted to prevent future falls. The facility policy Fall Protocol dated 3/10/26, identified the purpose was to ensure timely, accurate, and appropriate assessment and documentation of all fall events, while identifying and addressing potential risk factors to prevent recurrence and enhance resident safety. Following a fall the staff would conduct a post fall huddle involving all staff present or involved and gather and document relevant details. The nurse would document the fall event under the risk management tab in the facility system. The nurse would ensure the who, what, where, why and how the fall occurred was included. The nurse would complete the post fall analysis report and update the resident's care plan and Kardex to reflect new fall prevention interventions.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the consulting pharmacist (CP) identified and acted upon an irregularity for psychotropic medications for 1 of 1 resident (R2) reviewed who was on a psychotropic medication. Findings include: R2's significant change Minimum Data Set (MDS) dated [DATE], identified R2 had intact cognition and was dependent on staff for activities of daily living (ADLs). R2 had not exhibited any behavioral symptoms. Diagnoses included Parkinson's disease, paraplegia, dysfunction of bladder, cardiomyopathy, dysphagia, hallucinations, and unspecified mental disorder due to known physiological condition. R2's Physician Progress Note for Nursing Home Visit dated 2/5/26, identified R2 was being seen by R2's primary care provider (PCP)-A for gastrointestinal concerns and tremors. The assessment/plan was identified as splenic infarct-ultrasound of abdomen complete, anemia- complete blood count with differential, hallucinations - quetiapine (Seroquel) 25 milligrams (mg) one time per day, and gastroesophageal reflux disease- omeprazole 20 mg one time per day. The plan identified R2 would resume Seroquel 25 mg per day as it had seemed R2 was better on the medication. A complete blood count (CBC) was ordered and a scheduled ultrasound. After the visit, an abnormal CBC and hemoglobin was identified and R2 was sent to the emergency department for further evaluation. Although R2 PCP-A restarted the Seroquel there was no identification of new onset of symptoms warranting the antipsychotic medication. R2's physician order dated 2/9/26, identified and order for quetiapine fumarate (Seroquel and antipsychotic) 25 milligrams (mg) to be given one time per day related to hallucinations.R2's Pharmacy Consultant Medication Review/Recommendations dated 2/23/26, identified R2 had medication changes as well as recent hospitalization. Seroquel, low dose, was restarted as R2 seemed better with it. Warfarin adjusted, vitamin K added, potassium increased, and omeprazole restarted. Multiple lab results noted and hypokalemia resolved. No recommendations. R2's medical record lacked evidence of R2 having any hallucinations, delusional thoughts, inappropriate communication or removing his clothing nor was there any ongoing behavioral monitoring.During interview on 3/24/26, at 3:46 p.m. RN-A stated staff and R2's spouse had been noting an increase in R2's tremors since his Seroquel had been stopped. RN-A thought R2 had been using his PRN carbidopa/levodopa more frequently, nearly daily since the Seroquel had been stopped. She had addressed the increase tremors with R2's PCP, and he had restarted the Seroquel. RN-A was sure there was weekly psychotropic medication monitoring for side effects but was unable to find any documentation of targeted behaviors such as hallucinations. RN-A thought the spouse had reported the behaviors, but it had not been documented. During telephone interview on 3/24/26, at 4:54 p.m. the consulting pharmacist (CP)-B stated he usually looked at the resident discharge summary and would have looked to see if the physician indicated the psychotropic medication was restarted for a psychotic episode or delusions. CP-B knew R2 had a diagnosis of hallucinations for the medication, and the medication was at a low dose. R2's physician would have never started Seroquel for tremors. CP-B had not reviewed if behavior or hallucinations had been monitored and/or documented for R2. CP-B did not review the physician indications for the restart of the medication and had just noted the medication had been restarted with a diagnosis of hallucinations. CP-B would have certainly commented if the indication for the restart of Seroquel was listed as tremors.The facility policy Psychotropic Medications dated 3/10/26, identified physicians and mid-level providers would use psychotropic medications appropriately working with the interdisciplinary team to ensure appropriate use, evaluation and monitoring. The facility would support the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of environmental, medical, and/or behavioral interventions, as well as psychopharmacological medications could be utilized to meet the needs of the individual resident. The pharmacist and/or consulting pharmacist would monitor (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychotropic drug use in the facility to ensure that medications were not used in excessive doses or for excessive duration. The CP would participate in the interdisciplinary quarterly review of residents on psychoactive medications and notify the physician and the nursing unit if/when a psychotropic medication was past due for review.