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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 4F36
Facility ID: 00614

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245438**

2. STATE VENDOR OR MEDICAID NO. (L2) **885463000**

3. NAME AND ADDRESS OF FACILITY
(L3) **TALAHI NURSING AND REHAB CENTER**
(L4) **1717 UNIVERSITY DRIVE SOUTHEAST**
(L5) **SAINT CLOUD, MN** (L6) **56304**

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) **06/01/2013**

6. DATE OF SURVEY **02/09/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12. Total Facility Beds **77** (L18)

13. Total Certified Beds **77** (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
	77			
(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 :
Jessica Sellner, Unit Supervisor 02/09/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 02/10/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **02/01/1987** (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
Posted 02/23/2015 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **01/29/2015** (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245438
February 9, 2015

Ms. Lisa Udy, Administrator
Talahi Nursing And Rehab Center
1717 University Drive Southeast
Saint Cloud, Minnesota 56304

Dear Ms. Udy:

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 the above facility is certified for or recommended for:

77 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 77 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
February 9, 2015

Ms. Lisa Udy, Administrator
Talahi Nursing And Rehab Center
1717 University Drive Southeast
Saint Cloud, Minnesota 56304

RE: Project Number S5438026

Dear Ms. Udy:

On January 6, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 19, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On February 9, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 19, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 27, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 19, 2014, effective January 27, 2015 and therefore remedies outlined in our letter to you dated January 6, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992   Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245438	A. Building B. Wing	2/9/2015

Name of Facility	Street Address, City, State, Zip Code
TALAHI NURSING AND REHAB CENTER	1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304

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

(Y4) Item ID Prefix	Reg. #	LSC	(Y5) Date Correction Completed
F0166	483.10(f)(2)		01/27/2015
F0225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)		01/27/2015
F0226	483.13(c)		01/27/2015
F0242	483.15(b)		01/27/2015
F0279	483.20(d), 483.20(k)(1)		01/27/2015
F0364	483.35(d)(1)-(2)		01/27/2015
F0431	483.60(b), (d), (e)		01/27/2015

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	JS/KJ	2/9/2015	29249	2/9/2015
Reviewed By CMS RO				

Followup to Survey Completed on: 12/19/2014

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

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
February 9, 2015

Ms. Lisa Udy, Administrator
Talahi Nursing And Rehab Center
1717 University Drive Southeast
Saint Cloud, Minnesota 56304

Re: Reinspection Results - Project Number S5438026

Dear Ms. Udy:

On February 9, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 19, 2014, with orders received by you on January 6, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

AH Form Approved

2/9/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00614	A. Building B. Wing	2/9/2015

Name of Facility	Street Address, City, State, Zip Code
TALAHI NURSING AND REHAB CENTER	1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **20560** Reg. # **MN Rule 4658.0405 Subp. 2** LSC	**01/27/2015**	ID Prefix **20960** Reg. # **MN Rule 4658.0600 Subp. 1** LSC	**01/27/2015**	ID Prefix **21045** Reg. # **Mn Rule 4658.0620 Subp. 4** LSC	**01/27/2015**
ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Subd. :** LSC	**01/27/2015**	ID Prefix **21630** Reg. # **MN Rule 4658.1350 Subp. 2 A.I** LSC	**01/27/2015**	ID Prefix **21880** Reg. # **MN St. Statute 144.651 Subd. 2** LSC	**01/27/2015**
ID Prefix **21980** Reg. # **MN St. Statute 626.557 Subd. 3** LSC	**01/27/2015**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	JS/KJ	2/9/15	29249	2/9/15

Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 12/19/2014

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 4F36

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00614

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245438**

2. STATE VENDOR OR MEDICAID NO.
(L2) **885463000**

3. NAME AND ADDRESS OF FACILITY
(L3) **TALAHI NURSING AND REHAB CENTER**
(L4) **1717 UNIVERSITY DRIVE SOUTHEAST**
(L5) **SAINT CLOUD, MN** (L6) **56304**

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) **06/01/2013**

6. DATE OF SURVEY **12/19/2014** (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)
12/31

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

12.Total Facility Beds **77** (L18)

13.Total Certified Beds **77** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	77			
(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
Annette Truebenbach, HFE NE II
Date : 01/17/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL
Anne Kleppe, Enforcement Specialist
Date: 01/23/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(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

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 6, 2015

Ms. Lisa Udy, Administrator
Talahi Nursing And Rehab Center
1717 University Drive Southeast
Saint Cloud, Minnesota 56304

RE: Project Number S5438026

Dear Ms. Udy:

On December 19, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - 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;**
>
> **<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7365

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 January 28, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 19, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 19, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

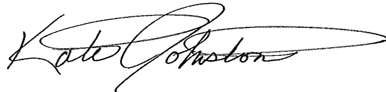
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,



Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
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
	245438	A. BUILDING ______ B. WING ______	12/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAHI NURSING AND REHAB CENTER	**1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R40) who's family member (FM-A) voiced a grievance, received prompt efforts on behalf of the facility to resolve their concerns, related to vertical blinds in need of repair. Findings include: During interview on 12/16/14, at 1:28 p.m. FM-A expressed concerns with the vertical blinds in R40's resident room. FM-A stated a portion of the blind (one slat) was missing, which resulted in the inability to block the streetlight outside her window from coming in the window. FM-A stated	F 166	F166 The facility failed to ensure prompt efforts were made to resolve grievances for 1 of 1 resident (R40) whose family member voiced a concern related to vertical blinds in the room that needed repair. R 40's room was checked by maintenance and repairs were made to the blinds at the time of survey. Staff were re-educated on the grievance policy, maintenance request policy, and the formal grievance form that the resident	1/27/15

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

Electronically Signed — 01/14/2015

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

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	245438	A. BUILDING ______ B. WING ______	12/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAHI NURSING AND REHAB CENTER	**1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304**

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F 166	Continued From page 1 she had voiced her concern to facility personnel on multiple occasions over the past two years, including the maintenance department and nursing staff on the facility's East wing; however, nothing had been done to resolve the issue. Observation of R40's resident room on 12/16/14, at 2:01 p.m. confirmed the vertical blinds had a slat missing. The missing slat left a four to six inch gap in the center of the window when the vertical blinds were shut, allowing outside light to shine into the room. During interview on 12/18/14, at 8:58 p.m. nursing assistant (NA)-C stated she was not sure how long R40's vertical blinds had been missing the center slat, but she was aware another staff had told her maintenance tried to fix it, but the slat kept falling out of place. During interview on 12/18/14, at 2:15 p.m. maintenance (M)-A verified R40's vertical blinds were missing the center slat. M-A stated staff and residents tried to open and close vertical blinds without first opening the slats, which lead to broken slats. M-A stated he had ordered a new track for R40's blinds and was awaiting its arrival. During interview on 12/19/14, at 8:23 a.m. M-B stated he tried to fix R40's vertical blinds many times in the five months he worked at the facility. M-B stated the person who worked in his position prior, had also tried to fix the vertical blinds in R40's room, but stated, "It works for a while and then it breaks again... I know they [facility management] have either ordered a new bar for it or they are going to order one. They are trying to decide what to do about the blinds in this place because they are always breaking. I replace five or six a day, especially on that [the East] wing." A follow-up interview on 12/19/14, at 8:30 a.m. FM-A stated the vertical blinds in R40's room had	F 166	and or families may use to record their concerns or complaints on, 1-6-15.Those staff unable to attend will be given a makeup packet or re-educated at mini in-services during their regular shift hours. To ensure continued timely resolution of concerns room audits will be completed for all residents by maintenance and any repairs that are needed will be completed promptly. Quarterly residents and or families will be interviewed regarding maintenance concerns during care conferences and any concerns will be brought promptly to the maintenance department for repair. Maintenance director will summarize the findings from the audits and present it to the QA committee for further review and recommendations.	

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F 166	Continued From page 2 been broken for at least two years. FM-A stated she had reported this to many of the staff in the facility over many months. FM-A stated she had also reported her concern to the previous maintenance staff and had brought M-B into R40's room a couple months prior to show him the broken vertical blind. FM-A stated M-B told her they had tried to fix it. FM-A stated, "It's totally ridiculous. The string is very tough to pull so I think the staff gets frustrated with trying to open and close it, so sometimes when I visit during the day, the blinds aren't even opened..." During interview on 12/19/14, at 8:59 a.m. M-A and the facility administrator stated there was no purchase order for the new track for the blinds because one hadn ' t been ordered. M-A stated, "We're working on it with corporate... I told [administrator] two months ago that something needed to be done." The administrator stated, "We will need to figure out which ones need to be fixed and put that in our budget. I know it's [the blinds] a problem." Review of the facility's Grievance Policy dated 10/23/14, instructed, "Upon receiving an oral complaint, Social Services, or the appropriate supervisor, will interview all parties involved and take immediate action to remedy the complaint, if possible..."	F 166		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide	F 225		1/27/15

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F 225	Continued From page 3 registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of abuse/ neglect to the state agency (SA) and facility administrator, for 1 of 4 residents (R31) reviewed for incidents of alleged maltreatment.	F 225	F225 The facility failed to report allegations of abuse immediately to the administrator and state agency for 1 of 4 residents (R31).	

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F 225	Continued From page 4 Findings include: R31's care plan dated 10/5/14, identified a diagnosis of peripheral neuropathy, functional bladder incontinence related to physical limitations, neurogenic disorder, and required assistance of two staff to use the commode for toileting. A facility Resident and Family Concerns Form dated 11/12/14, identified 11/10/14, R31 had put her call light on for assistance to use a bedpan at 5:30 a.m. R31 had pressed her call light for assistance when finished, however, the call light was not answered until 7:15 a.m. The Concern form indicated R31 reported pain in her legs and was crying because of the incident. The investigation section of the form indicated the call light reports confirmed R31 call light had been on for a total of 121 minutes prior to being answered. The form was signed by the facility administrator, social worker and director of nursing (DON) on 11/13/14, three days after the incident. There was no indication the administrator was notified immediately after the incident of possible neglect, no report was submitted to the SA, and there was no indication of the results of an investigation for possible neglect. During interview on 12/17/14, at 9:45 a.m. DON confirmed R31's incident was not immediately reported to the facility administrator and/or the SA. The DON stated she had done some re-education with the nursing assistant involved regarding re-approaching any resident within ten minutes of being put on a bedpan. In addition, the call system was found to be malfunctioning (no visual display in hall) and was repaired at the	F 225	Administrator was updated on 12-16-14. Staff were re-educated on 1-6-15 on the resident protection policy and procedure for reporting vulnerable adult situations and what to report and when to report and whom to report to. Staff that were unable to attend will be given a makeup packet or re-educated at a mini in-service during their regular shift hours. DON or designee will audit 20 staff a week for 1 month then 20 staff monthly for 2 more months and as needed thereafter to ensure knowledge of reporting procedures, what is reportable and to ensure continued compliance. DON will summarize findings of audits and present them to the QA committee for further recommendations and changes.	

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F 225	Continued From page 5 time of the incident. When interviewed by the DON after the incident, R31 stated she didn't believe her leg pain was directly related to the incident, so the DON felt it was not reportable since R31 had not experienced injury. The DON stated looking back on the incident with R31, it should have been reported immediately to the SA and administrator for possible neglect. The facility's Resident Protection policy dated 10/23/14, directed any incidence of alleged abuse be reported immediately to the SA and the facility administrator.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement abuse prohibition procedures related to immediate reporting of alleged abuse/ neglect to the state agency (SA) and facility administrator, for 1 of 4 residents (R31) reviewed for incidents of alleged maltreatment. Findings include: The facility's Resident Protection policy dated 10/23/14, directed any incidence of alleged abuse/ neglect should be reported immediately to	F 226	F226 The facility failed to implement their abuse prohibition policy for 1 of 4 residents (R31) reviewed which was not reported immediately to the administrator and state agency. Staff were re-educated on 1-6-15 on the resident protection policy and procedure for reporting vulnerable adult situations and what to report, and when to report and whom to report it to. Staff who were unable to attend will be given a makeup packet or re-educated at a mini in-service	1/27/15

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F 226	Continued From page 6 the SA and the facility administrator. R31's care plan dated 10/5/14, identified a diagnosis of peripheral neuropathy, functional bladder incontinence related to physical limitations, neurogenic disorder, and required assistance of two staff to use the commode for toileting. A facility Resident and Family Concerns Form dated 11/12/14, identified 11/10/14, R31 had put her call light on for assistance to use a bedpan at 5:30 a.m. R31 had pressed her call light for assistance when finished, however, the call light was not answered until 7:15 a.m. The Concern form indicated R31 reported pain in her legs and was crying because of the incident. The investigation section of the form indicated the call light reports confirmed R31 call light had been on for a total of 121 minutes prior to being answered. The form was signed by the facility administrator, social worker and director of nursing (DON) on 11/13/14, three days after the incident. There was no indication the administrator was notified immediately after the incident of possible neglect, no report was submitted to the SA, and there was no indication of the results of an investigation for possible neglect. During interview on 12/17/14, at 9:45 a.m. DON confirmed R31's incident was not immediately reported to the facility administrator and/or the SA according to the facility policy. The DON stated she had done some re-education with the nursing assistant involved regarding re-approaching any resident within ten minutes of being put on a bedpan. In addition, the call system was found to be malfunctioning (no visual display in hall) and was repaired at the time of the incident. When	F 226	during their regular shift hours. The DON or designee will audit 20 staff a week for a month ensure staff are aware of the reporting procedures and are following the policy then 20 staff monthly for 2 more months and as needed thereafter. DON will summarize the findings of the audits and present it to the QA committee for further review and recommendations.	

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F 226	Continued From page 7 interviewed by the DON after the incident, R31 stated she didn't believe her leg pain was directly related to the incident, so the DON felt it was not reportable since R31 had not experienced injury. The DON stated looking back on the incident with R31, it should have been reported immediately to the SA and administrator for possible neglect.	F 226		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review, the facility failed to accommodate menu choices, for 2 of 2 residents (R20 and R23) with expressed requests for alternate menu options. Findings include: R20's quarterly Minimum Data Set (MDS) dated 8/26/14, identified R20 had no cognition impairment. During interview on 12/17/14, at 8:07 a.m. R20 stated she had selected the hot dog instead of a chicken patty for supper the evening prior because she did not like the chicken patty, however, she was told she could not have the hot	F 242	The facility failed to accommodate menu choices for 2 of 2 residents (R20 and R23) with expressed requests for alternate menu options. These residents along with all residents will be offered alternative menu items as necessary. With all meals an alternative menu option will be offered and made available. Staff were educated on 1-6-15 on the Residents Preferences Policy to ensure staff are providing for residents preferences. Staff not able to attend will be given a makeup packet or educated at mini-inservices held during regularly scheduled shifts. To ensure compliance with alternative menu choices the dietary manager or designee will be conducting	1/27/15

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F 242	Continued From page 8 dog by a nursing staff member. R20 stated this morning she was told she could not have a fried egg and stated whenever she asked for alternates to what is on the menu the answer was "No, no, no!" R20 had tears in her eyes and stated she wished the facility had a, "Better system of serving us." During interview on 12/18/14, at 8:23 a.m. the dietary director (DD) stated she was not aware of any concerns with the facility's serving process in the dining room and making alternative menu options available to residents. She stated R20 should have been able to receive a hot dog instead of the chicken patty if she wanted, and R20 should have been offered another food item if she did not like what was on the menu. R23's quarterly MDS dated 11/22/14, indicated the resident had no cognitive impairment. During observation and interview on 12/17/14, at 9:20 a.m. R23 requested fried eggs for breakfast. Nursing assistant (NA)-A told R23 there were no fried eggs, and offered R23 French toast and sausage. R23 agreed to the alternate offered, and NA-A brought toast and sausage to R23's room. R23 declined the toast and ate two bites of the sausage. R23 told NA-A the sausage was hard to eat and too cold. During interview on 12/17/14, at 12:10 p.m. DD confirmed the kitchen staff had not made fried eggs that day, however, R23 could have had scrambled eggs. R23 was not offered scrambled eggs as an alternate. DD stated the facility staff tried to accommodate menu choices for residents.	F 242	audits on 20 residents a week for 4 weeks, then 20 residents a month for one month and as needed to ensure alternative menu choices are offered as requested. Dietary Manager will summarize the findings of audits and present them to the QA Committee for further recommendations and changes.	

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F 279	Continued From page 9	F 279		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan to include nutrition non-compliance and interventions staff can attempt to encourage compliance for 1 of 1 residents, (R91), who recieve dialysis at an outside facility, and for 1 of 3 residents, (R17), reviewed for pain. Findings include: R91's admission Minimum Data Set (MDS) dated 11/6/14, indicated R91 had diagnosis including	F 279	F279 The facility failed to develop a comprehensive care plan to include nutrition non-compliance and interventions staff can attempt to encourage compliance for 1 of 1 residents, (R91), who receive dialysis at an outside facility, and for 1 of 3 residents, (R17), reviewed for pain. Talahi Nursing & Rehab Center uses the results of the assessments to develop, review and revise the residents care plan.	1/27/15

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F 279	Continued From page 10 End Stage Renal Disease (ESRD), had a therapeutic diet, and was recieving dialysis. The Care Area Assessment (CAA) Summary dated 11/6/14, indicated under nutritional status and dehydration/fluid maintenance the care area triggered related to this being a concern with R91, and was checked to be addressed in the care plan. R91's Physician order dated 10/30/14, instructed staff R91 was to recieve a modified diabetic diet, regular consistency, dialysis diet, with 1500 milliliters (ml) fluid restriction. R91's Dietary Assessment dated 11/10/14, identified R91 did not follow diet restrictions. The nursing assistant (NA) West Group I sheet noted R91 was on a dialysis / diabetic diet and a 1500 ml fluid restriction. R91's care plan dated 11/14/14, identified the resident had acute/chronic renal failure related to chronic kidney disease, and was currently receiving dialysis. The care plan did not address the non-compliance with the prescribed diet, or interventions staff should be implementing to encourage compliance with the resident prescribed diet. R91 Nutrition Note dated 12/2/14, indicated staff reported resident goes out of facility regularly for long periods of time and chooses not to comply with dialysis diet in or out of the facility at times. During interview on 12/17/14, at 1:35 p.m. dietary director (DD) stated R91 is very non-compliant with her diet, and frequently leaves the facility for	F 279	For residents R17 and R91 the care plan was updated to reflect the pain and nutritional non-compliance on 12/19/14. Staff were re-educated at the time of survey when the concern was noted on 12/19/14 and at a staffing meeting on 1-6-15 on the dialysis policy and procedure as well as the care plan policy and procedure to ensure accurate care plans are created and reflect the resident's pain and nutritional needs. Staff who are unable to attend will be given a makeup packet or will be re-educated at a mini in-service during their regular shift hours. 12 audits of care plans will be completed on a weekly basis for 6 weeks and then at least quarterly thereafter. The DON will summarize the findings of the audits and present it to the QA committee for further review and recommendations.	

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F 279	Continued From page 11 a full day and eats out. DD also stated she has educated R91 on what is not allowed on the diet. When interviewed on 12/19/14, at 11:00 a.m. registered dietician (RD) stated she has not provided any education to R91 regarding the importance of following the prescribed diet since her admission to the facility several months ago. RD also stated she had not left any education for staff to provide R91, and stated she will definitely speak to R91 during her visit in January. RD stated R91's care plan did not address the residents specific dietary needs, and interventions staff could attempt to try to encourage complaince, however, RD stated the care plan should contain the information for staff. When interviewed on 12/19/14, at 11:25 a.m. the director of nursing (DON) stated she would expect staff to address concerns related to dialysis according to the dialysis policy, which addressed items such as diet and treatment, which included assessing and promoting diet adherence. Facility policy titled Dialysis Program Guidelines revision date 9/2014, noted to assess contributing factors for non-compliance. Under coordination of care planning activities for dietary, related to monthly assessment and care plan, the consultant RD completes a monthly nutrition assessment and care plan reviews. The policy indicated these assessments are based upon food fluid intake, weight patterns, diet adherence, and laboratory values. R17's admission MDS dated 10/16/14, identified the resident had no cognitive impairment, had pain frequently during the last five days, and rated	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245438	A. BUILDING ______ B. WING ______	12/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAHI NURSING AND REHAB CENTER	1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304

(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 279	Continued From page 12	F 279		

her pain a 9 out of 10 (Pain scale, worse pain being a 10, no pain being a 1).

R17's CAA dated 10/16/14, indicated pain was a care issue for R17 and should be addressed on the care plan.

Nursing assistant West Group 2 sheet did not address R17's pain.

R17's care plan dated 10/28/14, did not address R17's costant daily pain.

During interview on 12/16/14, at 2:22 p.m. R17 stated she had continuous pain in her back daily and was recieving care at an outside clinic.

During interview on 12/19/14, at 10:30 a.m. registered nurse (RN)-A stated pain was not included on R17's care plan and the resident is currently seeing a lumbar specialist. RN-A verified pain should have been added to R17's care plan and was not done.

When interviewed on 12/19/14, at 11:30 a.m. DON stated pain was not included in R17's care plan and verified it should be. DON stated she was going to provide education to the staff regarding this.

The facility policy titled Pain Management dated 11/2014, instructed staff to initiate and/or update care plans to include type of pain, required monitoring including pain management plan, and a measurable goal relating to the pain management plan.

The facility policy titled Care Plan dated 10/2014, instructed the CAAs will be used to complete a

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TALAHI NURSING AND REHAB CENTER	**1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304**

(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 279	Continued From page 13 comprehensive care plan for the residents by day 21.	F 279		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review the facility failed to serve food at a palatable temperature for 3 of 5 residents (R23, R7 and R84) who complained of cold and unpalatable food. Findings include: R23's quarterly Minimum Data Set (MDS) dated 11/22/14, indicated his cognition was intact. A Nutrition/Dietary note dated 5/19/14, indicated R23 felt the food served at the facility did not taste good or look appealing, was not served at the proper temperature, and R23 felt by the time he received his food it was cold. During interview on 12/16/14, at 9:24 a.m. R23 stated he ate meals in his room and the food was cold when it got to his room and it needed to be reheated. During observation and interview on 12/17/14, at 9:20 a.m. nursing assistant (NA)-A brought toast	F 364	Facilty failed to serve food at a palatable temperature for 3 of 5 residents (R23, R7, and R84)who complained of cold and unpalatable food. These residents along with all residents will be offered food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Dietary manager or designee will do 20 residents food audits per week for four weeks and then 20 residents food audits for one month and as needed to ensure food is at acceptable temperature when delivered to the table or the residents room. There will be 20 residents a week audited for satisfaction of meals and concerns and then 20 residents a month and as needed to ensure that residents are receiving palatable, appealing, warm food. New insulated plates and covers were purchased to provide for warmer food brought to residents rooms. Dietary manger will summarize the findings of	1/27/15

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F 364	Continued From page 14 and sausage to R23's room. R23 declined the toast and ate two bites of sausage. R23 told NA-A the sausage was hard to eat and was cold. During interview on 12/17/14, at 9:47 a.m. cook (C)-A stated the room trays sat on a cart during the dining room meal service until NAs were available to bring them to resident rooms. During interview on 12/18/14, at 8:39 a.m. R23 stated, "The staff had to reheat my hard boiled eggs, I can tell because they are rubbery when they reheat them." R7's admission MDS dated 11/28/14, identified the resident had no cognitive impairment. During interview in the main dining room on 12/17/14, at 8:40 a.m. R7 stated her food was very cold. R7 stated, "They need a better system for serving the food around here, when it comes it is cold!" R7 stated she was upset and had wheeled out of the dining room the previous evening due to cold food and waiting an extended time for her tray. R7's food was delivered from the kitchen during observation and consisted of eggs, toast and sausage links. R7 stated the food was cold as soon as it was brought out, "Just feel it!" Temperatures of R7's food were taken and revealed the eggs were at 80 degrees Fahrenheit (F), the toast was 80 degrees F and the sausage was 85 degrees F. The dietary director (DD) was present while temperatures were checked and stated the food was not at an acceptable temperature for palatability. DD stated the food may have lost temperature while being carried from the steam table to R7's seat which was approximately 30 feet away. DD stated the eggs were initially cooked to 170	F 364	audits and present them to the QA Committee for further recommendations and changes.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAHI NURSING AND REHAB CENTER	**1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304**

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F 364	Continued From page 15 degrees F and the meat to 165 degrees F, however, the food must have lost temperature waiting to be served. R84's significant change MDS dated 11/28/14, identified the resident had no cognitive impairment. During interview on 12/15/14, at 3:49 p.m. R84 stated her food and coffee was usually cold when she received her room tray, and cold food was a problem at every meal. During interview on 12/18/14, at 8:23 a.m. the DD stated she had been made aware of complaints about food temperatures within the last two weeks, particularly with regard to room trays and stated staff should have been auditing food temperatures prior to serving each meal. The DD stated there were more residents on room trays and the aides were not always taking them out right away. The facility's Safe Food Temperatures policy dated 3/14, indicated food was to be maintained at safe and palatable temperatures during meal service, and all hot foods were to be held at 140 degrees or above.	F 364		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431		1/27/15

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F 431	Continued From page 16 reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure Fentanyl (narcotic analgesic) patches were destroyed according to facility policy to ensure prevention of potential diversion for 4 of 4 residents (R26, R50, R63 and R79) reviewed with prescribed Fentanyl patches. Findings include: R26 physician order dated 5/2/14, included an	F 431	F431 The facility failed to ensure fentanyl patches were destroyed in a manner to prevent potential diversion for 4 of 4 residents (R26, R50, R63, and R79). On 12/18/2014 4 of 4 residents EMARs were updated to reflect the proper procedure of fentanyl patch disposal and correlating documentation. Audits of the narcotic books were also initiated on	

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TALAHI NURSING AND REHAB CENTER	**1717 UNIVERSITY DRIVE SOUTHEAST** **SAINT CLOUD, MN 56304**

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F 431	Continued From page 17 order for a 75 microgram (mcg) per hour Fentanyl Patch to be applied transdermally (on the skin) every 72 hours. R50 physician order dated 9/9/14, included an order for a 25 mcg per hour Fentanyl Patch to be applied transdermally every 72 hours. R63 physician order dated 10/15/14, included an order for a 25 mcg per hour, as well as a 100 mcg per hour, Fentanyl Patch to be applied transdermally every 72 hours. R79 physician order dated 11/11/14, included an order for 50 mcg per hour Fentanyl Patch to be applied transdermally every 72 hours. During medication storage review on 12/17/14, at 7:32 a.m. licensed practical nurse (LPN)-A stated the facility practice was to have two nurses witness the waste of the used Fentanyl patches, but it was not documented anywhere by the second nurse who acted as the witness. LPN-A stated since the facility had changed electronic medical record systems, there was not a place to document the signature of the 2nd nurse witnessing the destruction. During interview on 12/17/14, at 2:07 p.m. the director of nursing (DON) stated there should be a spot on the electronic medication administration record (eMAR) for both nurses to sign off the destruction of the used Fentanyl patches. Upon review of R26, R50, R63 and R79's eMARs, DON confirmed there was no signature by a second nurse to verify the witnessed destruction, nor was there an area in which the second nurse could document.	F 431	12/19/14 for proper documentation of patch disposal. Staff were re-educate on the policy and procedure for proper documentation of the patch disposal on 1-6-15. Those staff unable to attend will be given a makeup packet or re-educated at a mini in-service during their regular shift hours. Audits will be done twice a week on those residents whom have a fentanyl patch order for 2 months then as needed to ensure continued compliance. The DON will summarize the audit findings and present it to the QA committee for further review and recommendations.	

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F 431	Continued From page 18 During interview on 12/17/14, at 2:17 p.m. LPN-B stated the Narcotic book was not used to document the witnessed destruction of the used Fentanyl patches nor was there anywhere in the new electronic medical record system for the staff to document the witnessed destruction of the Fentanyl patches. R26, R50, R63 and R79's Individual Narcotic Record in the Narcotic book (the log used to track the administration of narcotic medications) were reviewed. Each record lacked evidence which showed the used Fentanyl patches were destroyed and witnessed by two nurses according to the facility policy. Review of the facility policy titled Controlled Substances dated 9/14, instructed staff were to have two licensed nurses flush the used patches into the sewer system and document the destruction by both nurses signing off in the Narcotic book. The second nurse was to sign their name under the verified column.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245438	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 12/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALAHI NURSING AND REHAB CENTER	**1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Talahi Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Talahi Center is a 2-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1964 and was determined to be of Type II(000) construction. In 1984, an addition was added to the north which was determined to be of Type II(000)construction. Both of these buildings are 1 story building with partial basements. In 1998 and addition was added to the northwest that was determined to be Type II(000) construction and is 2 stories with no basement. In 2004 two additions were added to to the north that were determined to be Type II(000) construction and are both 2 stories with no basements. The plans for these 2 additions were reviewed on 02-03-03 to the 1985 Life Safety Code. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a complete fire sprinkler system. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor that is	K 000		

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

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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	245438	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	12/17/2014

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K 000	Continued From page 1 monitored for automatic fire department notification. The facility has a licensed capacity of 77 beds and had a census of 72 at the time of the survey.	K 000		

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
January 6, 2015

Ms. Lisa Udy, Administrator
Talahi Nursing And Rehab Center
1717 University Drive Southeast
Saint Cloud, Minnesota 56304

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5438026

Dear Ms. Udy:

The above facility was surveyed on December 15, 2014 through December 19, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency 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 attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule 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.

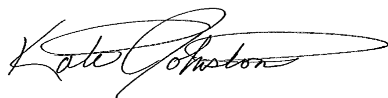
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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 me.

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,



Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00614	A. BUILDING: ______ B. WING ______	12/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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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	00614	A. BUILDING: ______ B. WING ______	12/19/2014

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TALAHI NURSING AND REHAB CENTER	1717 UNIVERSITY DRIVE SOUTHEAST SAINT CLOUD, MN 56304

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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 12/15/14 - 12/19/14 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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	00614	A. BUILDING: ______ B. WING ______	12/19/2014

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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		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan to include nutrition non-compliance and interventions staff can attempt to encourage compliance for 1 of 1 residents, (R91), who recieve dialysis at an outside facility, and for 1 of 3 residents, (R17), reviewed for pain. Findings include: R91's admission Minimum Data Set (MDS) dated 11/6/14, indicated R91 had diagnosis including End Stage Renal Disease (ESRD), had a therapeutic diet, and was recieving dialysis. The Care Area Assessment (CAA) Summary dated 11/6/14, indicated under nutritional status and dehydration/fluid maintenance the care area	2 560	Corrected	1/27/15

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2 560	Continued From page 3 triggered related to this being a concern with R91, and was checked to be addressed in the care plan. R91's Physician order dated 10/30/14, instructed staff R91 was to recieve a modified diabetic diet, regular consistency, dialysis diet, with 1500 milliliters (ml) fluid restriction. R91's Dietary Assessment dated 11/10/14, identified R91 did not follow diet restrictions. The nursing assistant (NA) West Group I sheet noted R91 was on a dialysis / diabetic diet and a 1500 ml fluid restriction. R91's care plan dated 11/14/14, identified the resident had acute/chronic renal failure related to chronic kidney disease, and was currently receiving dialysis. The care plan did not address the non-compliance with the prescribed diet, or interventions staff should be implementing to encourage compliance with the resident prescribed diet. R91 Nutrition Note dated 12/2/14, indicated staff reported resident goes out of facility regularly for long periods of time and chooses not to comply with dialysis diet in or out of the facility at times. During interview on 12/17/14, at 1:35 p.m. dietary director (DD) stated R91 is very non-compliant with her diet, and frequently leaves the facility for a full day and eats out. DD also stated she has educated R91 on what is not allowed on the diet. When interviewed on 12/19/14, at 11:00 a.m. registered dietician (RD) stated she has not provided any education to R91 regarding the importance of following the prescribed diet since	2 560		

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2 560	Continued From page 4	2 560		

her admission to the facility several months ago. RD also stated she had not left any education for staff to provide R91, and stated she will definitely speak to R91 during her visit in January. RD stated R91's care plan did not address the residents specific dietary needs, and interventions staff could attempt to try to encourage complaince, however, RD stated the care plan should contain the information for staff.

When interviewed on 12/19/14, at 11:25 a.m. the director of nursing (DON) stated she would expect staff to address concerns related to dialysis according to the dialysis policy, which addressed items such as diet and treatment, which included assessing and promoting diet adherence.

Facility policy titled Dialysis Program Guidelines revision date 9/2014, noted to assess contributing factors for non-compliance. Under coordination of care planning activities for dietary, related to monthly assessment and care plan, the consultant RD completes a monthly nutrition assessment and care plan reviews. The policy indicated these assessments are based upon food fluid intake, weight patterns, diet adherence, and laboratory values.

R17's admission MDS dated 10/16/14, identified the resident had no cognitive impairment, had pain frequently during the last five days, and rated her pain a 9 out of 10 (Pain scale, worse pain being a 10, no pain being a 1).

R17's CAA dated 10/16/14, indicated pain was a care issue for R17 and should be addressed on the care plan.

Nursing assistant West Group 2 sheet did not

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2 560	Continued From page 5	2 560		

address R17's pain.

R17's care plan dated 10/28/14, did not address R17's costant daily pain.

During interview on 12/16/14, at 2:22 p.m. R17 stated she had continuous pain in her back daily and was recieving care at an outside clinic.

During interview on 12/19/14, at 10:30 a.m. registered nurse (RN)-A stated pain was not included on R17's care plan and the resident is currently seeing a lumbar specialist. RN-A verified pain should have been added to R17's care plan and was not done.

When interviewed on 12/19/14, at 11:30 a.m. DON stated pain was not included in R17's care plan and verified it should be. DON stated she was going to provide education to the staff regarding this.

The facility policy titled Pain Management dated 11/2014, instructed staff to initiate and/or update care plans to include type of pain, required monitoring including pain management plan, and a measurable goal relating to the pain management plan.

The facility policy titled Care Plan dated 10/2014, instructed the CAAs will be used to complete a comprehensive care plan for the residents by day 21.

SUGGESTED METHOD OF CORRECTION:
The director of nursing and/or their designee could review and revise all resident care plans to include comprehensive plans for service, addressing all appropriate areas identified through assessment. Facility policies and

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2 560	Continued From page 6 procedures related to the development of resident care plans could be developed, with revisions made as appropriate and retraining provided to pertinent employees. A system for auditing on-going compliance with this statue could be developed, with results reviewed by the facility's Quality Assessment & Assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 960	MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This MN Requirement is not met as evidenced by: Based on observation, interview and documentation review the facility failed to serve food at a palatable temperature for 3 of 5 residents (R23, R7 and R84) who complained of cold and unpalatable food. Findings include: R23's quarterly Minimum Data Set (MDS) dated 11/22/14, indicated his cognition was intact. A Nutrition/Dietary note dated 5/19/14, indicated R23 felt the food served at the facility did not taste good or look appealing, was not served at the proper temperature, and R23 felt by the time he received his food it was cold. During interview on 12/16/14, at 9:24 a.m. R23	2 960	Corrected	1/27/15

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2 960	Continued From page 7 stated he ate meals in his room and the food was cold when it got to his room and it needed to be reheated. During observation and interview on 12/17/14, at 9:20 a.m. nursing assistant (NA)-A brought toast and sausage to R23's room. R23 declined the toast and ate two bites of sausage. R23 told NA-A the sausage was hard to eat and was cold. During interview on 12/17/14, at 9:47 a.m. cook (C)-A stated the room trays sat on a cart during the dining room meal service until NAs were available to bring them to resident rooms. During interview on 12/18/14, at 8:39 a.m. R23 stated, "The staff had to reheat my hard boiled eggs, I can tell because they are rubbery when they reheat them." R7's admission MDS dated 11/28/14, identified the resident had no cognitive impairment. During interview in the main dining room on 12/17/14, at 8:40 a.m. R7 stated her food was very cold. R7 stated, "They need a better system for serving the food around here, when it comes it is cold!" R7 stated she was upset and had wheeled out of the dining room the previous evening due to cold food and waiting an extended time for her tray. R7's food was delivered from the kitchen during observation and consisted of eggs, toast and sausage links. R7 stated the food was cold as soon as it was brought out, "Just feel it!" Temperatures of R7's food were taken and revealed the eggs were at 80 degrees Fahrenheit (F), the toast was 80 degrees F and the sausage was 85 degrees F. The dietary director (DD) was present while temperatures were checked and stated the food was not at an	2 960		

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2 960	Continued From page 8	2 960		

acceptable temperature for palatability. DD stated the food may have lost temperature while being carried from the steam table to R7's seat which was approximately 30 feet away. DD stated the eggs were initially cooked to 170 degrees F and the meat to 165 degrees F, however, the food must have lost temperature waiting to be served.

R84's significant change MDS dated 11/28/14, identified the resident had no cognitive impairment.

During interview on 12/15/14, at 3:49 p.m. R84 stated her food and coffee was usually cold when she received her room tray, and cold food was a problem at every meal.

During interview on 12/18/14, at 8:23 a.m. the DD stated she had been made aware of complaints about food temperatures within the last two weeks, particularly with regard to room trays and stated staff should have been auditing food temperatures prior to serving each meal. The DD stated there were more residents on room trays and the aides were not always taking them out right away.

The facility's Safe Food Temperatures policy dated 3/14, indicated food was to be maintained at safe and palatable temperatures during meal service, and all hot foods were to be held at 140 degrees or above.

SUGGESTED METHOD OF CORRECTION:
The facility's dietary director could review and revise dietary policies and procedures, evaluating a way to ensure food is served at palatable temperatures. A plan could be developed and implemented to ensure palatable food

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2 960	Continued From page 9 temperatures. Pertinent employees could be retrained on these plans and policies. A system for auditing on-going compliance could be developed, with the results being presented to the facility's Quality Assessment & Assurance committee. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 960		
21045	Mn Rule 4658.0620 Subp. 4 Frequency of Meals; Dining Room Subp. 4. Dining room. Meals are to be served in a specified dining area consistent with the resident's choice and plan of care. This MN Requirement is not met as evidenced by: F242 SUGGESTED METHOD OF CORRECTION: The facility's dietary director or designee could review/ revise policies and procedures, with retraining of pertinent employees, as appropriate to ensure resident choice in meal selection and dining processes are honored. Resident preferences could be reviewed with plans for honoring preferences updated as appropriate. A system to audit on-going compliance could be developed, with the results being reviewed by the Quality Assessment & Assurance committee. TIME PERIOD FOR CORRECTION: Tewnty-one (21) days.	21045	Corrected	1/27/15
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control	21426		1/27/15

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21426	Continued From page 10 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 residents (R39, R72 and R97) received initial symptom screening for tuberculosis (TB). Findings include: R39 was admitted to the facility on 7/1/10. R39's undated Resident Immunization Record lacked any evidence of an initial TB symptom screening. R72 was admitted to the facility on 10/6/14. R72's undated Baseline TB Screening Tool for Nursing Home and Boarding Care Residents had a blank TB symptom screening section.	21426	Corrected	

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21426	Continued From page 11 R97 was admitted to the facility on 8/13/14. R97's undated Baseline TB Screening Tool for Nursing Home and Boarding Care Residents had a blank TB symptom screening section. During interview on 12/17/14, at approximately 2:30 p.m. the director of nursing (DON) confirmed the TB screening forms lacked the required symptom screening. The facility policy titled Tuberculosis Program-Residents dated 7/14, indicated a baseline screening tool and TB history were to be completed for signs and symptoms of TB within 72 hours of admission. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review and revise the facility's TB policies and procedures to ensure appropriate symptom screening was completed. Pertinent personnel could be re-trained on these procedures. An auditing system could be developed for on-going compliance, with the results of those audits being presented to the facility's Quality Assessment & Assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance	21630		1/27/15

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21630	Continued From page 12 discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure Fentanyl (narcotic analgesic) patches were destroyed according to facility policy to ensure prevention of potential diversion for 4 of 4 residents (R26, R50, R63 and R79) reviewed with prescribed Fentanyl patches. Findings include: R26 physician order dated 5/2/14, included an order for a 75 microgram (mcg) per hour Fentanyl Patch to be applied transdermally (on the skin) every 72 hours. R50 physician order dated 9/9/14, included an order for a 25 mcg per hour Fentanyl Patch to be applied transdermally every 72 hours.	21630	Corrected	

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Continued From page 13

R63 physician order dated 10/15/14, included an order for a 25 mcg per hour, as well as a 100 mcg per hour, Fentanyl Patch to be applied transdermally every 72 hours.

R79 physician order dated 11/11/14, included an order for 50 mcg per hour Fentanyl Patch to be applied transdermally every 72 hours.

During medication storage review on 12/17/14, at 7:32 a.m. licensed practical nurse (LPN)-A stated the facility practice was to have two nurses witness the waste of the used Fentanyl patches, but it was not documented anywhere by the second nurse who acted as the witness. LPN-A stated since the facility had changed electronic medical record systems, there was not a place to document the signature of the 2nd nurse witnessing the destruction.

During interview on 12/17/14, at 2:07 p.m. the director of nursing (DON) stated there should be a spot on the electronic medication administration record (eMAR) for both nurses to sign off the destruction of the used Fentanyl patches. Upon review of R26, R50, R63 and R79's eMARs, DON confirmed there was no signature by a second nurse to verify the witnessed destruction, nor was there an area in which the second nurse could document.

During interview on 12/17/14, at 2:17 p.m. LPN-B stated the Narcotic book was not used to document the witnessed destruction of the used Fentanyl patches nor was there anywhere in the new electronic medical record system for the staff to document the witnessed destruction of the Fentanyl patches.

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21630	Continued From page 14 R26, R50, R63 and R79's Individual Narcotic Record in the Narcotic book (the log used to track the administration of narcotic medications) were reviewed. Each record lacked evidence which showed the used Fentanyl patches were destroyed and witnessed by two nurses according to the facility policy. Review of the facility policy titled Controlled Substances dated 9/14, instructed staff were to have two licensed nurses flush the used patches into the sewer system and document the destruction by both nurses signing off in the Narcotic book. The second nurse was to sign their name under the verified column. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review and revise policies and procedures for handling controlled substances. A procedure for destruction of Fentanyl patches could be included in those revisions, with pertinent employees being re-trained on processes. An auditing system could be developed to ensure on-going compliance, with the results of these audits being reviewed by the facility's Quality Assessment and Assurance committee. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21630		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as	21880		1/27/15

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patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place.

Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.

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21880	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R40) who's family member (FM-A) voiced a grievance, received prompt efforts on behalf of the facility to resolve their concerns, related to vertical blinds in need of repair. Findings include: During interview on 12/16/14, at 1:28 p.m. FM-A expressed concerns with the vertical blinds in R40's resident room. FM-A stated a portion of the blind (one slat) was missing, which resulted in the inability to block the streetlight outside her window from coming in the window. FM-A stated she had voiced her concern to facility personnel on multiple occasions over the past two years, including the maintenance department and nursing staff on the facility's East wing; however, nothing had been done to resolve the issue. Observation of R40's resident room on 12/16/14, at 2:01 p.m. confirmed the vertical blinds had a slat missing. The missing slat left a four to six inch gap in the center of the window when the vertical blinds were shut, allowing outside light to shine into the room. During interview on 12/18/14, at 8:58 p.m. nursing assistant (NA)-C stated she was not sure how long R40's vertical blinds had been missing the center slat, but she was aware another staff had told her maintenance tried to fix it, but the slat kept falling out of place. During interview on 12/18/14, at 2:15 p.m. maintenance (M)-A verified R40's vertical blinds were missing the center slat. M-A stated staff and residents tried to open and close vertical blinds without first opening the slats, which lead to broken slats. M-A stated he had ordered a new track for R40's blinds and was awaiting its arrival.	21880	Corrected	

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During interview on 12/19/14, at 8:23 a.m. M-B stated he tried to fix R40's vertical blinds many times in the five months he worked at the facility. M-B stated the person who worked in his position prior, had also tried to fix the vertical blinds in R40's room, but stated, "It works for a while and then it breaks again... I know they [facility management] have either ordered a new bar for it or they are going to order one. They are trying to decide what to do about the blinds in this place because they are always breaking. I replace five or six a day, especially on that [the East] wing."
A follow-up interview on 12/19/14, at 8:30 a.m. FM-A stated the vertical blinds in R40's room had been broken for at least two years. FM-A stated she had reported this to many of the staff in the facility over many months. FM-A stated she had also reported her concern to the previous maintenance staff and had brought M-B into R40's room a couple months prior to show him the broken vertical blind. FM-A stated M-B told her they had tried to fix it. FM-A stated, "It's totally ridiculous. The string is very tough to pull so I think the staff gets frustrated with trying to open and close it, so sometimes when I visit during the day, the blinds aren't even opened..."

During interview on 12/19/14, at 8:59 a.m. M-A and the facility administrator stated there was no purchase order for the new track for the blinds because one hadn ' t been ordered. M-A stated, "We're working on it with corporate... I told [administrator] two months ago that something needed to be done." The administrator stated, "We will need to figure out which ones need to be fixed and put that in our budget. I know it's [the blinds] a problem."

Review of the facility's Grievance Policy dated 10/23/14, instructed, "Upon receiving an oral

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21880	Continued From page 18 complaint, Social Services, or the appropriate supervisor, will interview all parties involved and take immediate action to remedy the complaint, if possible..." SUGGESTED METHOD OF CORRECTION: The facility administrator, maintenance personnel and/or their designees could tour the facility to identify maintenance concerns and develop a plan for repair. Facility policies and procedures related to grievances and maintenance repairs could be reviewed and revised as necessary. Facility employees could be retrained on these policies and the grievance procedure. Processes for reporting needed repairs could also be reviewed with facility personnel. Repair plans could then be implemented. A system to audit ongoing compliance could be developed and initiated, with the results reviewed by the Quality Assessment & Assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:	21980		1/27/15

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(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or

(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).

(b) A person not required to report under the provisions of this section may voluntarily report as described above.

(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.

(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.

(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the

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facility failed to immediately report allegations of abuse/ neglect to the state agency (SA) and facility administrator, for 1 of 4 residents (R31) reviewed for incidents of alleged maltreatment.

Findings include:

R31's care plan dated 10/5/14, identified a diagnosis of peripheral neuropathy, functional bladder incontinence related to physical limitations, neurogenic disorder, and required assistance of two staff to use the commode for toileting.

A facility Resident and Family Concerns Form dated 11/12/14, identified 11/10/14, R31 had put her call light on for assistance to use a bedpan at 5:30 a.m. R31 had pressed her call light for assistance when finished, however, the call light was not answered until 7:15 a.m. The Concern form indicated R31 reported pain in her legs and was crying because of the incident. The investigation section of the form indicated the call light reports confirmed R31 call light had been on for a total of 121 minutes prior to being answered. The form was signed by the facility administrator, social worker and director of nursing (DON) on 11/13/14, three days after the incident. There was no indication the administrator was notified immediately after the incident of possible neglect, no report was submitted to the SA, and there was no indication of the results of an investigation for possible neglect.

During interview on 12/17/14, at 9:45 a.m. DON confirmed R31's incident was not immediately reported to the facility administrator and/or the SA. The DON stated she had done some re-education with the nursing assistant involved regarding re-approaching any resident within ten

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21980	Continued From page 21 minutes of being put on a bedpan. In addition, the call system was found to be malfunctioning (no visual display in hall) and was repaired at the time of the incident. When interviewed by the DON after the incident, R31 stated she didn't believe her leg pain was directly related to the incident, so the DON felt it was not reportable since R31 had not experienced injury. The DON stated looking back on the incident with R31, it should have been reported immediately to the SA and administrator for possible neglect. The facility's Resident Protection policy dated 10/23/14, directed any incidence of alleged abuse be reported immediately to the SA and the facility administrator. METHOD OF CORRECTION: The director of nursing and/or their designee could review abuse prohibition policies and procedures, revising them as appropriate. Facility personnel could be re-trained on reporting procedures. Recent incidents/ concern reports could be reviewed to determine whether other mistreatment concerns exist, with proper reports made. A system for auditing compliance with this statute could be developed with the results being reviewed by the Quality Assessment & Assurance Committee. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21980		